

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County

City or town

*Post Reformation Funeral*  
*Sudden Landing*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Alexander Arons*

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M*

*Wife*

*Divorced*

6. (b) Name of husband or wife

7. Birth date of

deceased (mo. day, yr.)

6. (c) If alive, give age

years

*July 15 1887*

8. AGE:

Years

Months

Days

11 less than one day

*59*

*10*

*15*

hrs.

min.

9. Birthplace

(Town, county, and state)

*Parisica*

10. Usual occupation

*REAL ESTATE*

11. Industry or business

*Solomon Arons*

12. Name

*Rebecca*

13. Birthplace

*unknown*

14. Maiden name

*unknown*

15. Birthplace

*unknown*

16. Informant

*not known*

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

6-5-47  
(month) (day) (year)

Cemetery or crematory

*Harry Nieberg & Son*

Location

*141 Ludlow St., New York City*

18. Funeral director

*Lee & O'Gallagher Son*

Address

*Bethesda, Md.*

19. Date rec'd by registrar

*June 5 1947*

*Irene E. Daugherty*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

KINGS

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

*May 30*

1947, at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

*Amputated*

Due to

*Body*

Due to

*airplane accident*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

*5/30-47*

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

*airplane*

Injured at work?

23. SIGNATURE

Medical Examiner

for

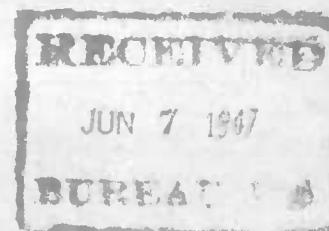
*Cecil County*

M. D. or other

Date signed

*6-4-47*

41



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03872

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town).

How long in above place of death:

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Alberta Bauch

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Seer

11. Industry or business

MOTHER FATHER

12. Name.....

Samuel Gold

13. Birthplace.....

Philadelphia, Pa.

14. Maiden name.....

Julie Gold

15. Birthplace.....

Canada

16. Informant.....

Eugene Simms

Address.....

Great Orange N.J.

17. Removal.....

Date thereof.....

6-3-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

DECEASED

To..... Philip Apter &amp; Son

Location.....

Newark, New Jersey

18. Funeral director.....

Lee A. Patterson

Address.....

Perryville, Md.

19. (Date rec'd by registrar)

June 3 1947

June 8 1947

Registrar.....

Address.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

ED7

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 30 1947 at 6425

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Dehydration of body.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?.....

23. SIGNATURE.....

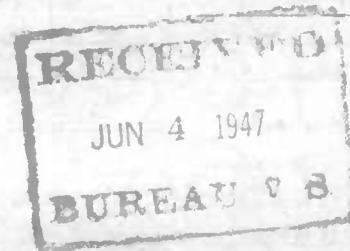
Medical Examiner.....

Cecil County.....

M. D. or other.....

Date signed.....

30



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

## CERTIFICATE OF DEATH

Reg. Dist. No. 0387496

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, Institution, or street address where death occurred.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Sheldon H Bauch.

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M. White Married Alberta Bauch.

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Aug 6 1900 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day hrs. min.

9. Birthplace..... Newark N.J. (Town, county, and state)

10. Usual occupation..... Restaurant

11. Industry or business..... Ward &amp; Bauch.

12. Name..... Ward &amp; Bauch.

13. Birthplace..... New York City

14. Maiden name..... Eda Grinbrowitz

15. Birthplace..... New York City

16. Informant..... Eugene Meeks

Address..... West Orange N.J.

17. Removal Date thereof..... 6-3-47

(Burial, cremation, or removal. Which?)

To..... Philip Apter &amp; Son

Cemetery or cemetery.....

Location..... Newark, New Jersey

18. Funeral director..... Leo A. Patterson &amp; Son

Address..... Perryville, Md.

19. June 3 1947 Name E. Daugherty

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... N.J.

County..... Essex

City or town..... Orange

(If outside city or town limits, write RURAL and give nearest town)

Street No. 251

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... May 30 1947 at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

end that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Inhalation of

Due to..... gas

Due to..... Acetylene Acid

DURATION

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Medical Examiner.....

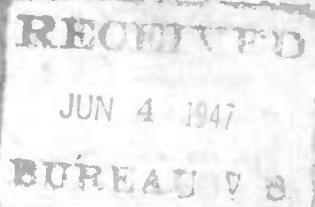
Signature..... Cecil County

M. D. or other.....

Date signed.....

Address.....

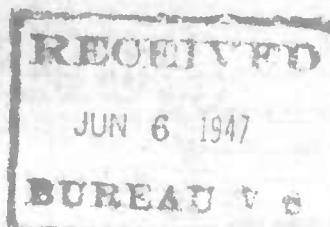
29





21

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JUN 6 1947





SEARCHED INDEXED SERIALIZED FILED

9

RECD IN FD

JUN 6 1947

BUREAU FD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830A

03878

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County.....  
Cecil  
City or town.....  
Perry Point, Md.

How long in above place of death?..... 15 days.

Hospital, institution, or street address where death occurred:

Veterans Administration

How long in hospital or institution?..... Same as above

## 3. (a) FULL NAME

BRADY, ERNEST H.

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife..... Mrs. Bertha Brady

## 7. Birth date of

deceased (mo., day, yr.)

April 19, 1872

years

## 8. AGE:

Years  
75Months  
0Days  
28If less than one day  
hrs. .... min.

9. Birthplace..... Baltimore County, Md.

(Town, county, and state)

10. Usual occupation..... Retired

## 11. Industry or business

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal.....

(Burial, cremation, or removal. Which?)

Date thereof..... May 17, 1947

(month) (day) (year)

Cemetery or crematory..... Rest Haven

Location..... Hagerstown, Md.

18. Funeral director..... L. F. Ricker

Address..... Funkstown 241.

19. 5/17 1947

(Date rec'd by registrar)

Irene E. Daugherty  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Funkstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... Spanish-American

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 17 1947 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 2 1947, to May 17 1947, and that I last saw him alive on May 17, 1947.

Immediate cause of death.....

Cerebral Hemorrhage

Uremia

Due to..... Generalized Arteriosclerosis

Due to.....

Other conditions..... Psychosis with Cerebral  
Arteriosclerosis  
(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

## 23. SIGNATURE

A. E. TROLLINGER, M.D., Clinical Director  
Veterans Administration Date signed 5/17/47  
Address..... Perry Point, Md.

RECEIVED

MAILS, V. L. M.

RECEIVED

MAY 20 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

## CERTIFICATE OF DEATH

Reg. Distr. No. 0387996

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Harold Burgess

4. Sex

M

Female

5. Color of face

6. (a) Single, married, widowed, or divorced

Divorced (?)

6. (b) Name of husband or wife

Unknown

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

May 1, 1918

8. AGE:

Years  
29Months  
0Days  
29If less than one day  
hrs. min.9. Birthplace ~~Myton Gates~~ Milby Borough Bridge  
(Town, county, state)

10. Usual occupation:

## 11. Industry or business

12. Name Claude H. Burgess

13. Birthplace Stourton, England

14. Maiden name Clara Marshall

15. Birthplace Leeds, England

16. Informant Clara Burgess

Address ~~Myton Gates~~ Milby Borough Bridge, Yorkshire, England

17. Removal

Date thereof 6-12-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory ~~Myton Gates~~ Milby Boro Bridge

Location Yorkshire, England (via NYC)

18. Funeral director Lee A. Patterson, son

Address Perryville, Md.

19. June 12 1947 - Irene E. daughter

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Country: ~~England~~ #2 Myton Gates

City or town Milby Boro Bridge, Yorkshire

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

809

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947 at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Decapitated  
Body.  
Airplane

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

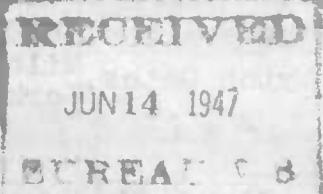
Dr. Cecil County

M. D. or other

Address

Date signed

6-5-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03880

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 1. PLACE OF DEATH:

County

Darien

(If outside city or town limits, write RURAL and give nearest town)

City or town Sudden standing

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Jan 3 1899

8. AGE:

Years

Months

Days

It less than one day

48

hrs. min.

9. Birthplace

Chicago Ill.

(Town, county, and state)

10. Usual occupation

True Trees Koppers Co

11. Industry or business

For ants Byrne

FATHER

12. Name

Ringgold Island and

13. Birthplace

Kingsbury Smith

14. Maiden name

Dorothy

15. Birthplace

Carl Glens

16. Informant

Koppers Co in Pittsburg

Address

17. Removal

Date thereof 6-3-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

18. Funeral director

To Kampp Funeral Home

Location

Chicago Ill.

19. Funeral director

Lee A. Patterson &amp; Son

Address

Terryville Md.

20. Date rec'd by registrar

June 3 1947 Irene Edgworth

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

St Louis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4943

Lindell Blvd.

2.(a) If veteran, name war

## 3. (b) Social Security Number

168-03-5075

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30

1947, at 642 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h... alive on

19...

Immediate cause of death

Aviation

DURATION

Due to

of body

Due to

Aviation accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

Medical Examiner

for

Cecil County

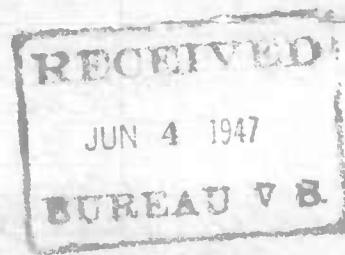
M. D. or other

Date signed

Address

Date signed

27



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03881

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

County..... *Baltimore County*  
 City or town..... *Chesapeake City*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *50 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex..... *Male* 5. Color or race..... *White* 6. (a) Single, married, widowed, or divorced..... *Married*

6. (b) Name of husband or wife..... *Mary Elizabeth*7. Birth date of deceased (mo., day, yr.)..... *May 24 1869* 6. (c) If alive, give age..... *78* years

8. AGE: Years..... *78* Months..... Days..... If less than one day.....  
 hrs..... min.....

9. Birthplace..... *Maryland* (Town, county, and state)10. Usual occupation..... *Blacksmith*

11. Industry or business.....

FATHER 12. Name..... *Edward Cartt*  
 13. Birthplace..... *Maryland*

MOTHER 14. Maiden name..... *Sarah Allen*  
 15. Birthplace..... *Maryland*

16. Informant..... *Mrs. George E. Scott*Address..... *Elkton, Maryland*Burial..... *Death Chesapeake City*

(Burial, cremation, or removal. Which?)

Date thereof..... *May 27-47* (month) (day) (year)Cemetery or crematory..... *Death Chesapeake City*Location..... *11th & 1/2 W. Main Street*18. Funeral director..... *Elkton*Address..... *Elkton, Md.*19. Date rec'd by registrar..... *May 26 1947*  
 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Baltimore*  
 City or town..... *Chesapeake City*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

197-16-3936

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *May 24 1947* at *3:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 1940* 19..... to *May 24* 19.....and that I last saw him alive on *May 24* 19.....Immediate cause of death..... *Acute cardiac decomp.*Due to..... *Chronic hypertension**Cardiovascular disease*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

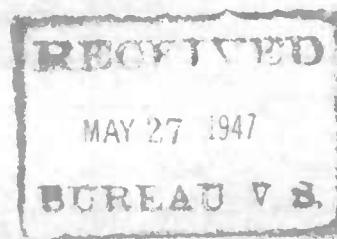
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *John Dorn* M. D. or otherAddress..... *Chesapeake City* Date signed *5/26/47*

RECEIVED BY TELETYPE STATE DEPARTMENT  
MAY 27 1947 10:45 A.M.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63882

173

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual occupation

## 11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location 1970 Broadway, New York City

18. Funeral director

Address Perryville, Md

19. (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

207

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. , 10. , 19.

and that I last saw h. alive on 19.

Immediate cause of death

Fractured

Body

Airplane and

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (Underline)

Means of injury

Injured at work?

Medical Examiner

Cecil County

23. SIGNATURE

M. D. or other

Date signed

Address

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45C

03883  
94

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Cecil  
 County: Charleston

City or town: Charleston  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days  
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William B Clayton

4. Sex: Male 5. Color or race: white 6. (a) Single, married, widowed, or divorced: Married

8. (b) Name of husband or wife: Bessie J Clayton 63 8. (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): April 5 1879

8. AGE: 68 Years 11 Months 25 Days It less than one day hrs. ..... min. .....

9. Birthplace: Charleston Md  
 (Town, county, and state)

10. Usual occupation: Mail Carrier

## 11. Industry or business

12. Name: David Clayton  
 13. Birthplace: Md

14. Maiden name: Ella Marshall  
 15. Birthplace: Md

16. Informant: Mrs William B Clayton  
 Address: Charleston Md

17. (Burial, cremation, or removal, which?) Burial Date thereof: 6-2-47  
 (month) (day) (year)

Cemetery or crematory: Charleston Cemetery

Location: Charleston Md

18. Funeral director: Joseph B Grant  
 Address: North East Md

19. (Date rec'd by registrar) 6-1 19 47 Lida S. Quinn  
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Charleston  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war: .....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

D.S.T.

20. DATE OF DEATH: 30 May 19 47 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 19 46 to 30 May 19 47

and that I last saw him alive on 29 May 19 47

Immediate cause of death: Adenocarcinoma of mouth  
with metastasis

DURATION 1 year

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide: ..... Date of .....

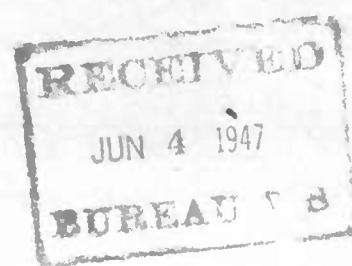
Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work? .....

23. SIGNATURE: Klaus H Hueber M.D. M. D. or other .....

Address: North East Md Date signed 30 May 47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03884

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Cecil  
 County Cecil  
 City or town Elkton, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 55 years  
 Hospital, Institution, or street address where death occurred  
221 Howard St  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Md County Cecil  
 City or town Elkton, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 221 Howard St  
 (If rural, give LOCATION)

## 3. (a) FULL NAME

Dora L. Cleaves

## 3. (b) Social Security Number

4. Sex F. 5. Color or race wh 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Henry M. Cleaves  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) Jan 28 1865  
 8. AGE: Years 82 Months 4 Days 0 If less than one day  
 hrs.  min.   
 9. Birthplace Bloomsburg Pa  
 (Town, county, and state)  
 10. Usual occupation at home  
 11. Industry or business

12. Name William L. Cleaves  
 13. Birthplace Pa  
 14. Maiden name Ann Jane Lyngton  
 15. Birthplace Pa

16. Informant Mrs. Frances Cleaves  
 Address 221 Howard St Elkton, Md

17. Burial  
 (Burial, cremation, or removal. Which?) Elkton  
 Cemetery or crematory Elkton  
 Location Elkton, Md

18. Funeral director H. W. Lipps  
 Address Elkton  
 Date May 31 1947 J. R. Fraser  
 (Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
19. 25 to May 28 1947  
 and that I last saw her alive on May 27 1947

Immediate cause of death Cerebral Embolism  
 DURATION 5 min.

Due to chronic endocarditis

Due to

Other conditions Chronic Intestinal  
Nephritis Arteriosclerosis, general  
 (Include pregnancy within 3 months of death)

Major findings or operations   
 Date of op.

Autopsy results   
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

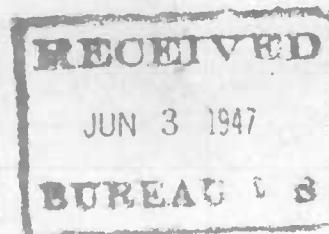
Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work

23. SIGNATURE Herbert Bates, M.D. M. D. or other

Address Elkton, Md Date signed May 28/47



**CERTIFICATE OF DEATH**

**M**  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**3. (a) FULL NAME**

Wm. Eritt Coney.

**3. (b) Social Security Number**

E07

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day yr)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

41

2

1

hrs.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

Aviator

11. Industry or business

Orbitor Motorcycles

12. Name

Orbitor Motorcycles

13. Birthplace

Baltimore

14. Maiden name

Mabel Colett

15. Birthplace

Baltimore Md.

16. Informant

Wm. H. Patterson

WOODIN

Address

STEWART & MOWEN CO.

17. (Burial, cremation, or removal. Which?)

Removal

Date thereof. 6 - 3 - 47

\* (month) (day) (year)

Baltimore

funeral director

Stewart & Mowen

CEMETERY: Loudon Park, Balt. Md.

Location

108 W. North Ave. Balt. Md.

18. Funeral director

Lee A. Patterson Son

Address

Glenville, Md.

19. Name

Wm. E. daughter

Date rec'd by registrar

Registrar

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State

Cola. County

City or town

Miami (If outside city or town limits, write RURAL and give nearest town)

Street No.

19. If rural, give LOCATION

2.(a) If veteran, name war.

World War II.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH

May 30 1947 at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

19.

and that I last saw h. alive on

19.

Immediate cause of death

Mutilated body

Due to

Aviation accident

Due to

Aviation accident

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (Where?)

Means of injury

Aviation accident

Injured at work?

Medical Examiner

Lee D. Darrow, M.D.

Medical County

M. D. or other

Baltimore, Md.

Date signed

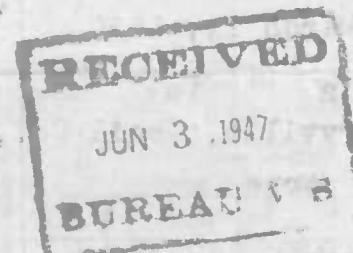
June 20, 1947

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JUN 4 1947

BUREAU V 8





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the  
charges made  
against

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore

173

03887

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

S 110 - 6/19/47

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

White

Single

6. (b) Name of husband or wife

7. Birth date of  
deceased (mo., day, yr.)

6. (c) If alive, give age

years

2000 years 8/24/47

8. AGE:

Years 44

Months 6

Days

It less than one day

hrs. 55

min.

9. Birthplace

Southport

Connecticut

England

(Town, county, and state)

10. Usual occupation

Import

er

er

porter

11. Industry or business

Ohan

Cavayoundjian

er

er

MOTHER FATHER

Name

12. Name

Ohan

Cavayoundjian

er

er

13. Birthplace

Mara

Bakirjian

er

er

MOTHER

Name

Maria

Bakirjian

er

er

FATHER

Name

Turkey

er

er

er

16. Informant

E.M. Sahagian

er

er

er

Address

152 W. 42st N.Y.

er

er

er

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

6-6-47

(month) (day) (year)

Date of

Accident

Date of

Suicide

Date of

Homicide

Date of

Cemetery or crematory

Frank E. Campbell, Inc.

Cause

of

Injury

Date

of

Death

Date

of

Cause

of

Injury

Date

of

Homicide

Date

of

Suicide

Date

of

Homicide

Date

of

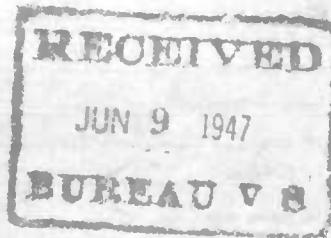
Injury

Date

of

Cause

7



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

03888

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: **Cecil**  
 County .....  
 City or town ..... **Perry Point**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? ..... **2 hrs.**  
 Hospital, Institution, or street address where death occurred:  
 .....  
 How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State ..... **Maryland** County ..... **Cecil**  
 City or town ..... **Perryville**,  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**John Bernhardt Dawson**

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
Male	White	Married		
6.(b) Name of husband or wife ..... <b>Pearl Blansfield Dawson</b>				
7. Birth date of deceased (mo., day, yr.) ..... <b>January 3, 1910</b>				
8. AGE:	Years	Months	Days	If less than one day
	37	4	13	hrs. ..... min.
9. Birthplace ..... <b>Perryville, Cecil Co., Md.</b> <small>(Town, county, and state)</small>				
10. Usual occupation ..... <b>Engineer, Work Equipment</b>				
11. Industry or business ..... <b>Penna. Rail Road</b>				
MOTHER, FATHER	12. Name	13. Birthplace ..... <b>Md.</b>		
	14. Maiden name ..... <b>Mary Little</b>			
MOTHER	15. Birthplace ..... <b>Cecil Co., Md.</b>			
	16. Informant ..... <b>Mary L. Dawson</b>			
Address ..... <b>Perryville, Md.</b>				
17. Burial ..... <b>Burial</b> <small>(Burial, cremation, or removal. Which?)</small>			Date thereof ..... <b>May 20, 1947</b> <small>(month) (day) (year)</small>	Date of ..... <b>5-17-47</b>
Cemetery or crematory ..... <b>Principio</b>			Where did injury occur? ..... <b>Perry Point, Cecil Co., Md.</b> <small>(City or town) (County) (State)</small>	
Location ..... <b>Principio Furnace, Md.</b>			Injured at home, farm, industry, public place (where?)	
18. Funeral director ..... <b>Lea Patterson &amp; Son</b>			Means of injury ..... <b>Automobile</b> Injured at work?	
Address ..... <b>Perryville, Md.</b>			Medical Examiner ..... <b>Le Rockenbach</b> for Cecil County	
19. Date rec'd by registrar ..... <b>May 20 1947</b> <b>Irene E. Daugherty</b> <small>(Date rec'd by registrar)</small>			M. D. or other ..... <b>Young &amp; Son</b> Date signed ..... <b>5/17/47</b>	

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... **May 17 1947** at **4Q.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. .... to 19. ....

and that I last saw h. .... alive on 19. ....

Immediate cause of death

*Fractured  
Spine &  
crushed Right  
side of chest*

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of ..... **5-17-47**Where did injury occur? ..... **Perry Point, Cecil Co., Md.**  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... **Automobile** Injured at work?Medical Examiner ..... **Le Rockenbach** for Cecil CountyM. D. or other ..... **Young & Son** Date signed ..... **5/17/47**Address ..... **Young & Son**

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MAY 21 1947

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

## CERTIFICATE OF DEATH

Reg. Dist. No. 03889

## 1. PLACE OF DEATH:

County

Elkton

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos

Hospital, institution, or street address where death occurred:

Crown Hospital

How long in hospital or institution? 4 mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Cecil

City or town

Perryville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Annie Cameron Deekman

## 3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Henry Deekman

7. Birth date of deceased (mo., day, yr.)

10-22-1873

8.(c) If alive, give age, years

8. AGE:

Years 73 Months 6 Days 26 If less than one day hrs. min.

9. Birthplace

North East, Cecil Md

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Robert Cameron

12. Name

Robert Cameron

13. Birthplace

Md

MOTHER FATHER

MOTHER FATHER

MOTHER FATHER

14. Maiden name

Annie Pearson

15. Birthplace

Md

16. Informant

Arthur Cameron

Address

Elkton, Md

17. (Burial, cremation, or removal, where?)

Burial Date thereof May 21-1947

(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Hagerstown, Md

18. Funeral director

Joseph R. Grant

Address

North East, Md

19. May 19 1947

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 18 May 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 April 1947 to 18 May 1947 and that I last saw her alive on 17 May 1947.

Immediate cause of death

Cerebral vascular accident

DURATION

Due to Hypertension, Cardiac and cerebral disease

Due to Arteriosclerosis due to age &amp; diabetes

Other conditions Hemiplegia, right

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

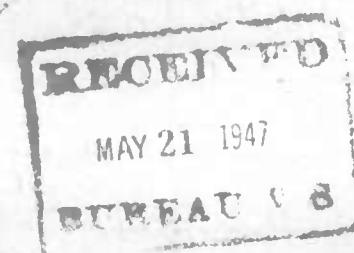
23. SIGNATURE

George J. Kueh, Jr. M.D.

M. D. or other

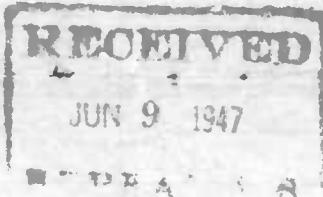
Address

Date signed 18 May 1947





5



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03891

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lillian Margaret Mills Delyea.

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M White Married

Victor F. Delyea.

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age ..... years

unknown

8. AGE:

Years Months Days If less than one day

50 hrs. min.

9. Birthplace

(Town, county, and state)

Toprovo Utah

10. Usual occupation

11. Industry or business

Harry Brown.

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947 at 642 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw h. alive on

19.

Immediate cause of death

DURATION

Pneumated

Body.

Due to

Airplaned

Due to

Airplaned

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)

Means of injury

Airplane Injured at work

Medical Examiner

All Dodson &amp; Son

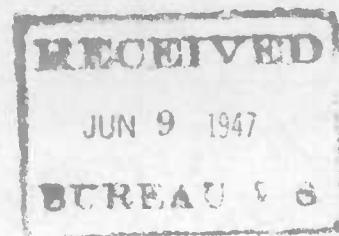
Public County

Resurgens

M. D. or other

6-4-47

88



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 113

03892

9c

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Sudden Landing

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Edward Donner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

White

Married

6. (b) Name of husband or wife

Sadie H. Donner

7. Birth date of deceased (mo., day, yr.)

March 18 1882

(b) If alive, give age

60

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Australia

(Town, county, and state)

10. Usual occupation

Lumber Merchant

11. Industry or business

G. H. Clumgire Donner

FATHER

12. Name

Ethel - unknown

MOTHER

13. Birthplace

Australia

14. Maiden name

Ethel - unknown

15. Birthplace

Australia

16. Informant

Beatrice Donner

17. Address

240 Central St. S. Nyat

18. R. M. V. C. &amp;

(Burial, cremation, or removal. Which?)

Date thereof

6 - 4 - 44

(month) (day) (year)

Cemetery or crematory

Riverside Chapel

Location

New York, New York

19. Funeral director

K. W. Patterson &amp; Son

Address

Perryville, Md.

20. Date rec'd by registrar

June 4, 1947

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

N.Y.

County

Bronx

City or town

New York City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1049

127th St

Bronx, N.Y.

(If rural, give location)

2. (a) If veteran, name war

## 3. (b) Social Security Number

EAE

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 30

1947

at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

19

and that I last saw h. alive on

19

Immediate cause of death

Suffocation

DURATION

Due to

of body

Due to

Aerogelane

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Aerogelane Injured at work?

Medical Examiner Old Dockwork Bldg. Cecil County

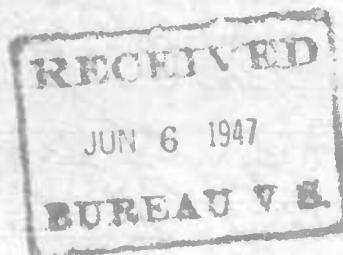
Signature: Young, Sam Date signed 6-14-47

M. D. or other

Address: Young, Sam Date signed 6-14-47

Q.

THE UNITED STATES GOVERNMENT  
FEDERAL BUREAU OF INVESTIGATION  
FEDERAL BUREAU OF INVESTIGATION



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03893

Reg. Dist. No. 92

## CERTIFICATE OF DEATH

89a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Cecil  
 County: Elkton R D 5 md  
 City or town: Elkton R D 5 md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 days  
 Hospital, Institution, or street address where death occurred: Elkton Hospital  
 How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State: Maryland County: Cecil  
 City or town: Elkton R D 5 md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)

## 3. (a) FULL NAME

Dolad Eastridge

## 3. (b) Social Security Number

4. Sex: Female 5. Color or race: white 6. (a) Single, married, widowed, or divorced: single

6. (b) Name of husband or wife: \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.): June 22 1934 8. (c) If alive, give age: \_\_\_\_\_ years8. AGE: Years: 12 Months: 11 Days: 9 If less than one day: \_\_\_\_\_ hrs: \_\_\_\_\_ min: \_\_\_\_\_9. Birthplace: Hawlock N. C (Town, county, and state)10. Usual occupation: at School11. Industry or business: E D Eastridge12. Name: E D Eastridge 13. Birthplace: Hawlock N. C14. Maiden name: Mary Ann Campbell 15. Birthplace: Hawlock N. C16. Informant: A D Eastridge 17. Removal: Elkton md R D 5Address: Elkton md R D 5 Date thereof: May 21 1947 (month) (day) (year)(Burial, cremation, or removal. Which?) Cemetery or crematory: West JeffersonLocation: North Carolina18. Funeral director: H. W. Pippin Address: Elkton. mdAddress: Elkton. md19. Date read by registrar: May 21 1947 Signature: J R Frazer Registrar: J R Frazer

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 May 1947 at 9:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 May 1947 to 21 May 1947 and that I last saw her alive on 20 May 1947Immediate cause of death: Meningitis, diffuse DURATION: 10 daysDue to: Meningitis, chronic, recurrent, left. 6 yrs.Due to: Otitis Media, chronic, recurrent, left. 6 yrs.

Other conditions: \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings or operations: \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

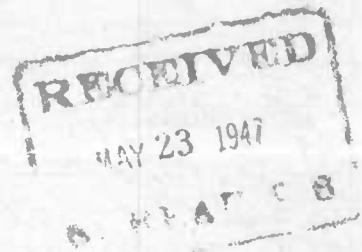
Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Cause of injury: \_\_\_\_\_ Injured at work: \_\_\_\_\_

23. SIGNATURE: Klaus H. Duermer M.D. M. D. or other: \_\_\_\_\_Address: North East, Md Date signed: 21 May 47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

193

03891  
96

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

CECIL  
U.S.N.T.C. BAINBRIDGE, MARYLAND

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Worked there 1/2 hrs.

Hospital, institution, or street address where death occurred:

of the day of death.

How long in hospital or institution?.....

## 3. (a) FULL NAME

LEON CAMPBELL EDDINGTON

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

MALE

WHITE

MARRIED

## 6. (b) Name of husband or wife.....

RAY IRA EDDINGTON

..... 6. (c) If alive, give age 47 years

## 7. Birth date of

deceased (mo., day, yr.) December 11, 1895

## 8. AGE:

Years

Months

Days

If less than one day

48

5

12

..... hrs.

..... min.

## 9. Birthplace.....

PHILADELPHIA, PENNA.

(Town, county, and state)

## 10. Usual occupation.....

RIGGER CIVIL SERVICE

## 11. Industry or business

## FATHER 12. Name

DONALD C. EDDINGTON

## 13. Birthplace

SCOTLAND

## MOTHER 14. Maiden name

Sarah Cory

England

## 15. Birthplace

VERNON A. EDDINGTON (son)

## 16. Informant

CHARLESTOWN, MARYLAND

Address

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

May 26-1947

## Cemetery or crematory

Methodist

## Location

Principio Maryland

Joseph R. Shantz

## 18. Funeral director

north East. Md

Address

## 19. May 24

1947

Irene E. Daugherty

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

MARYLAND

County.....

CECIL

City or town.....

PRINCIPAL FURNACE

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

23 May

1947

at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

## Immediate cause of death.....

ELECTRIC SHOCK

DURATION

Due to..... CONTACT.....

Due to.....

Other conditions..... Boom hit high tension wire + Eddyson  
had hand on crane [C/35/47.000]  
(include pregnancy within 8 months of death)

## Major findings or operations.....

Date of op.....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

5/23/47

Where did injury occur? Bambidae

(City or town) (County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury (see above)

Injured at work? yes

Medical Examiner  
for Cecil County

M. D. or other

Address..... Date signed.....



(not)







RECEIVED

JUN 5 1947

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

038972

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Cecil

City or town

Elk Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

years

Dece 24 1928

8. AGE:

Years

Months

Days

or less than one day

18

4

16

hrs.

min.

8. Birthplace

Gravensville N.C.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Paper mill

12. Name

Ozell Forrestor

13. Birthplace

Gravon Co Penn

14. Maiden name

Virginia E Forrest

15. Birthplace

Gratanga Co N.C.

16. Informant

Mrs. Ozell Forrestor

Address

Elk Mills

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 12, 1947

(month) (day) (year)

Cemetery or crematory

Elkton

Location

Elkton, Md

18. Funeral director

H.W. Rippin

Address

Elkton, Md

19. (Date rec'd by registrar)

May 12 1947

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

212-26-4164

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 10

1947 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h... alive on

19...

Immediate cause of death

Strangled

DURATION

Due to

Crushed right  
side of chest

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injur

Automobile Injured at work?

23. SIGNATURE

Medical Examiner

for Cecil County

M. D. or other

Date signed

Address

May 12 1947



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03898

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

M

H

B

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

14. Maiden name

15. Birthplace

18. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Flatbush Memorial Chapel

Location

1283 Coney Island Ave., Brooklyn, N.Y.

18. Funeral director

Lee S. Patterson &amp; Son

Address

Perryville, Md.

19. Date rec'd by registrar

June 4 1947 Irene E. Daugherty

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

City or town

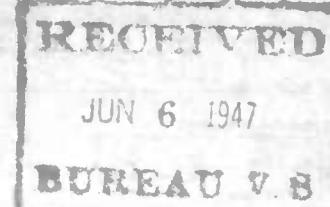
(If outside city or town limits, write RURAL and give nearest town)

Street No.

13

RECEIVED IN THE LIBRARY OF THE UNITED STATES HOUSE OF REPRESENTATIVES

60-210707-3000002



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03899

Reg. Dist. No.

96

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mona Gillberry

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

F. White Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

April 13 1829

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

hrs. min.

18 1 17

## 9. Birthplace

(Town, county, and state)

Peru.

## 10. Usual occupation

Mona

## 11. Industry or business

John E Gillberry

## 12. Name

Liverpool Eng

## 13. Birthplace

Bedford

## 14. Maiden name

Chile

## 15. Birthplace

Unknown

## 16. Informant

Address

## 17. Removal

Date thereof 6-6-47

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

P. M. Williams &amp; Son

## Location

St. Thomas, Ontario, Canada

## 18. Funeral director

H. A. Patterson &amp; Son

## Address

Peruville Md.

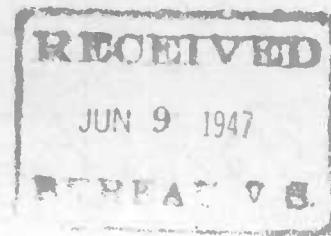
## 19. Date rec'd by registrar

June 6 1947

Date rec'd by registrar

## Date rec'd by registrar

52.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03909

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

hours

Hospital, Institution or street address where death occurred:

Union Hosp

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M White widowed

6. (b) Name of husband or wife.....

5. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 22 1882

8. AGE: Years

Months

Days

If less than one day

65 - 2 hrs. min.

9. Birthplace.....

Christiana Del

(Town, county, and state)

10. Usual occupation.....

Carpenter

11. Industry or business

FATHER

12. Name..... Joseph L. Goff Jr

13. Birthplace..... New Jersey

MOTHER

14. Maiden name..... No record

15. Birthplace..... No record

16. Informant.....

Charles A. Goff

Address.....

605 W 32nd Street

17. Burial place.....

Business

Date thereof..... May 27 47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Solomon Del

Location.....

Near Newark Del

18. Funeral director.....

R. J. Force

Address.....

Newark Del

19. Date rec'd by registrar.....

May 27 47

19.....

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

Ded

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 24 1947

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Acute Coronary

Thrombosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Medical Examiner

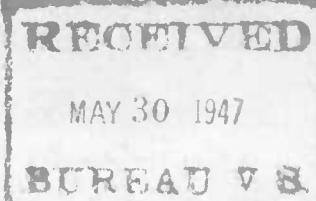
of Cecil County.....

M. D. or other

Address.....

R. J. Force

Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03901

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

M

MARGIN RESERVED FOR BINDING

VS A15 9:45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County

Cecil

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

15 days

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

15 days

## 3. (a) FULL NAME

William Charles Graw

4. Ss

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

B. (b) Name of husband or wife

Mattie H. Grant

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age

76 years

December 27 1865

8. AGE:

Years Months Days If less than one day  
81 4 18 hrs. min.

9. Birthplace

North East Md

(Town, county, and state)

10. Usual occupation

Basket maker

11. Industry or business

Charles Graw

12. Name

Mattie H. Grant

13. Birthplace

Md

14. Maiden name

Adams

15. Birthplace

Penns

16. Informant

Mattie H. Grant

Address

North East Md

17. Burial

Methodist

(Burial, cremation, or removal. Which?)

Date thereof May 19-47  
(month) (day) (year)

Cemetery or crematory

Methodist

Location

North East Md

18. Funeral director

Joseph A. Grant

Address

North East Md

19. May 18 47  
(Date rec'd by registrar)

19 47

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Cecil

City or town

North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

not a veteran

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

15 May 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 May 1947 to 15 May 1947 and that I last saw him alive on 15 May 1947.

Immediate cause of death

Cerebral Thrombosis

DURATION

6 hrs

Due to Generalized Arteriosclerosis

5 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Klaus H. Hucker M.D.

M. D. or other

Address North East Md Date signed 16 May 47

RECEIVED

MAY 21 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04741

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

## 1. PLACE OF DEATH:

County

Cecil  
North East Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Raymond C. Greenwood

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Oct 20 1894

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

51

7

8

hrs.

min.

9. Birthplace

Seneca Falls, Seneca Co., N.Y.

(Town, county, and state)

10. Usual occupation

Mechanical Engineer

11. Industry or business

Parson S. Greenwood

12. Name

Parson S. Greenwood

13. Birthplace

Marion, New York

14. Maiden name

Catharine A. Crossman

15. Birthplace

Corona, New York

16. Informant

Elma Greenwood

Address

North East. Md

17. Removal

May 31 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Corona

Location

Corona, Seneca Co. N.Y.

18. Funeral director

Joseph R. Grant

Address

North East. Md

19. 5/30

1946 Leda &amp; Elma

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town North East Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

Not a veteran

## 3. (b) Social Security Number

219-18-5086

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1946 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

May 25 1946 to May 25 1946

and that I last saw him alive on May 25 1946

Immediate cause of death

Coronary Thrombosis

DURATION

2 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

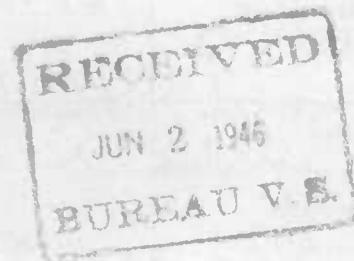
Injured at work?

23. SIGNATURE

D. Arlen Cummins M.D.

M. D. or other

Address May 24 1946 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03902

## CERTIFICATE OF DEATH

Reg. Dist. No. 9C

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Rafael A. Gutiérrez M.D.

## 3. (b) Social Security Number

E07

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

White

Married

## 6.(b) Name of husband or wife

Carmen R.D. Gutiérrez

## 7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age 38 years

## 8. AGE:

Years

Months

Days

If less than one day

..... hrs. .... min.

## 9. Birthplace

(Town, county, and state)

## 10. Usual occupation

Medical Doctor

## 11. Industry or business

FATHER

12. Name

Manuel

MOTHER

13. Name

Carmen

## 14. Maiden name

15. Birthplace

16. Informant

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 6-7-47  
(month) (day) (year)

## Cemetery or crematory

Location San Jose, Costa Rica

## 18. Funeral director

19. Date rec'd by registrar

Lee O. Patterson &amp; Son

Address Perryville, Md

20. Date rec'd by registrar

Address

21. Date rec'd by registrar

Address

22. Date rec'd by registrar

Address

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Costa Rica

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 30 1947 at 6420

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

to to

and that I last saw him alive on

## Immediate cause of death

Dutifully

Dobry

Anesthetized

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where)

Means of injury Medical Examiner

Injured at work for Cecil County

23. SIGNATURE M. D. or other

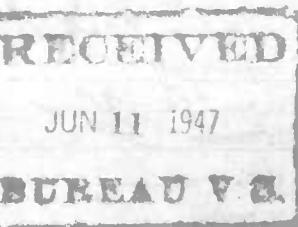
Address Date signed

Address

Address

Address

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9405

## CERTIFICATE OF DEATH

Reg. Dist. No. 039135

## 1. PLACE OF DEATH

Cecil

County

Conoway, rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7.5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Florence K. Hill

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

William Hill.

7. Birth date of

deceased (mo., day, yr.)

Aug. 12. 1871

years

6.(c) If alive, give age 76 years

8. AGE:

Years

Months

Days

If less than one day

75

9

15

hrs.

min.

9. Birthplace

Conoway, Md.

(Town, County, and state)

10. Usual occupation

Housewife

11. Industry or business

Stephen Hanna

12. Name

Stephen Hanna

Cecil Co. Md.

13. Birthplace

Cecil Co.

Md.

Elizabeth Johnson

Penna.

14. Maiden name

Elizabeth Johnson

Penna.

15. Birthplace

Penna.

16. Informant

Mr. William Hill.

Address

Conoway, Md.

A. H. D.

17. Burial

(Burial, cremation, or removal. Which?)

West Nottingham

Date thereof

May 31. 1947

(Month) (day) (year)

Cemetery or crematory

Near Colona, Md.

Location

Near Colona, Md.

18. Funeral director

J. E. Tyson

Address

Rising Sun, Md.

19. (Date rec'd by registrar)

May 29. 47

19.

Date signed

8-29-47

RECEIVED

MAY 31 1947

BUREAU U. S.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

175

03904

96

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

H.

Hut

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

March 191924

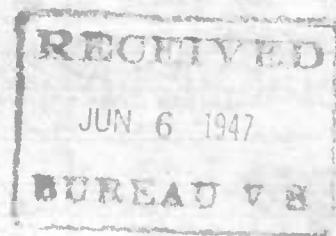
83 2 11

hrs.

min.

46  
NO. 39-10000-10000-10000-10000

RECEIVED TO STANISLAW



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03905

## CERTIFICATE OF DEATH

Reg. Dist. No. 0915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Cecil  
 County: Elkton

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 3 weeks

3. (a) FULL NAME

Frank L Hudson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white ?

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 25 1888

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>			
			hrs. <u>0</u> min. <u>0</u>

9. Birthplace

New Albany Ind

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

David L Hudson

12. Name

New Albany Ind

13. Birthplace

no information

14. Maiden name

no information

15. Birthplace

no information

16. Informant

Sophia E Steele

Address

Elkton Md

17. Burial

Date thereof May 22, 1947  
(Burial, cremation, or removal. Which?) Date (month) (day) (year)

Cemetery or crematory

Elkton Cemetery

Location

Elkton Maryland

18. Funeral director

H. W. Pippin

Address

Elkton Maryland

19. (Date rec'd by registrar)

May 21, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: CecilCity or town: Elkton (If outside city or town limits, write RURAL and give nearest town)Street No.:  (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1947 at 5:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1947 to May 20, 1947and that I last saw him alive on May 20, 1947 at 19:47

Immediate cause of death

Obstruction of the heart DURATION 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

Frank L Hudson Elkton Md May 22, 1947

RECEIVED

MAY 23 1947

BY RFA 8



RECEIVED

JUN 6 1947

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

168

03906

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Elmwood Hospital Elkhorn

How long in hospital or institution?

10 weeks

## 3. (a) FULL NAME

John Johnson

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. Col. single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

June 8, 1886

8. AGE: Years

Months

Days

If less than one day

66 hrs. min.

9. Birthplace.....

Maryland (Town, county, and state)

10. Usual occupation.....

Lobster

11. Industry or business

FATHER 12. Name..... JOHN JOHNSON

13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Elizabeth Riley

15. Birthplace..... Maryland

16. Informant..... Otis Harris

Address..... Cecilton, Md.

17. Burial.....

(Burial, cremation, or removal. Which)

Date thereof..... May 20 1947

(month) (day) (year)

Cemetery or crematory..... Cecilton

Location..... Cecilton, Md.

18. Funeral director..... Austin O. Cawle

Address..... 827 Pine St. Wilmer Del.

May 19 47

F. F. Fraser

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 16 1947 at 920 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death..... Peritonitis

Due to..... Ruptured bowel

Due to..... Probable trauma

Other conditions..... old left inguinal hernia

Hernia

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

definitely due to homicide [4-20-47 a/c]

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No homicide

Date of..... 5-15-47

Where did injury occur?..... Cecilton, Cecil, Md.

(City or town) County (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Flight

Injured at work?

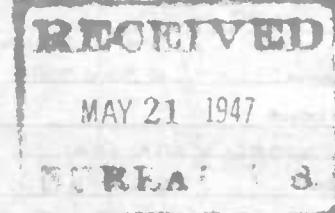
23. SIGNATURE.....

Medical Examiner M. D. or other

for Cecil County

Address.....

Date signed..... 5-15-47



PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore

03907

93d  
Reg. Dist. No.

94

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

Cecil

City or town.....

North East Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Adelia Ida Jones

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Married

8. (b) Name of husband or wife

Elmore H. Jones

7. Birth date of deceased (mo., day, yr.)

October 8 1864

8. (c) If alive, give age.....

72

years

8. AGE:

Years

Months

Days

If less than one day

82 7 4 hrs. min.

9. Birthplace.....

Rising Sun, Cecil Co., Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

George W. Chidester

12. Name.....

Md

13. Birthplace.....

Mary C. Preston

14. Maiden name.....

Md

15. Birthplace.....

Elmore H. Jones

16. Informant.....

Burial

Address.....

North East, Md

17. (Burial, cremation, or removal, which?)

Burial

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Union

Location.....

Elston Rural

bus

18. Funeral director.....

Joseph P. Grant

Address.....

North East, Md

19. (Date rec'd by registrar)

1947

5/18

Adelia Jones

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Cecil

City or town.....

North East Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

12 May 1947 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1946 to 12 May 1947

and that I last saw her alive on

11 May 1947

Immediate cause of death.....

Pulmonary Edema

DURATION

1 day

Due to..... Hypertensive Cardiovascular Disease

15 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

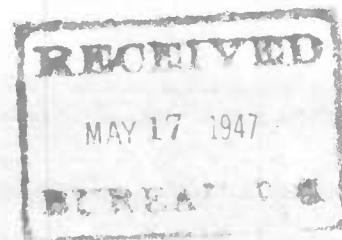
23. SIGNATURE.....

Hans H. Huchler M.D.

M.D. or other

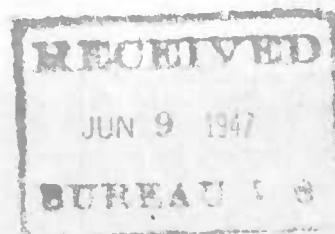
Address..... North East, Md Date signed 12 May 1947

Registrar





19



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03908

## CERTIFICATE OF DEATH

173  
Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lillie Katz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M  
glute married  
Benjamin Katz

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

Feb. 27 1897

8. AGE: Years Months Days If less than one day

50 3 3 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

Jacob Katz

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

18. Cemetery or crematory

Location

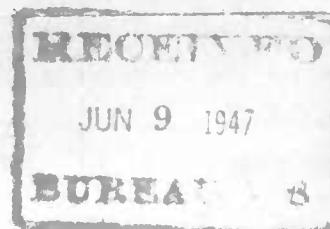
19. Funeral director

Address

20. Date rec'd by registrar

1947

4  
2



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03911

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

## 1. PLACE OF DEATH:

County

Desert  
Ont desert Rural

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

## 3. (a) FULL NAME

Bertha Kelman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

H

wife married

6. (b) Name of husband or wife

Joseph Kelman

7. Birth date of deceased (mo. day, yr.)

Aug 14 1895

62 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Haverstraw N.Y.

(Town, county, and state)

10. Usual occupation

Store Manager

11. Industry or business

Met Provitche

12. Name

Julia

FATHER

MOTHER

13. Birthplace

Russia

14. Maiden name

Sarah

15. Birthplace

Russia

16. Informant

M. Wm Smith

Address

863 Newbury St

17. Removal

(Burial, cremation, or removal. Which?)

18. Funeral director

Riverside Chapel

Location

New York City, N.Y.

19. Funeral director

Lee A. Patterson &amp; Son

Address

Perryville, Md.

20. Date rec'd by registrar

June 3 1949

21. Name of registrant

Dame E. Daugherty

22. Address

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

6730

15

47,642

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

19.

and that I last saw h... alive on

19.

Immediate cause of death

Hypertension

Due to

Hypertension

Due to

Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

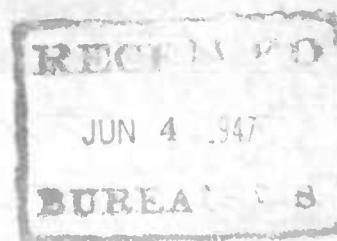
Medical Examiner

Cecil County

Date signed

Cecil County

25



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03912

## CERTIFICATE OF DEATH

173 Reg. Diat. No. 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Horace Reed King

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M Single Married

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

MOTHER FATHER

12. Name

John H King

13. Birthplace

## 14. Maiden name

MOTHER

15. Birthplace

## 16. Informant

Address

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

Philbrick Funeral Home

## Location

660 W. Flagler St. Miami, Fla.

## 18. Funeral director

Address

## 19. Date rec'd by registrar

19. Date of death

Address

20. Date of death

Address

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(If newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 30

1947 at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h. alive on

19...

## Immediate cause of death

Ingested  
body  
airplane

## Due to

## Due to

## Other conditions

## DURATION

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Medical Examiner

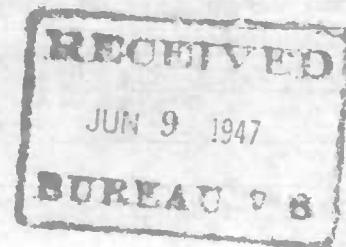
Cecil County

M. D. or other

Date signed

RECEIVED BY TELETYPE STATE DEPARTMENT

32.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

## CERTIFICATE OF DEATH

06913 96  
Reg. Distr. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age ... 38 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof. 6-4-47

Cemetery or crematory

Combs Funeral Home

Location

1539 N.E. 2nd Ave., Miami, Florida

18. Funeral director

Address

19. June 4 1947

(Date rec'd by registrar)

Irene E. Daugherty

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

E09

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to. 19.

and that I last saw h. alive on

Immediate cause of death

Inhalated

Due to. D. o. v. e. y.

Due to. a. i. r. o. p. l. a. n. e.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

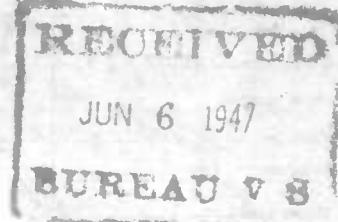
Medical Examiner

for Cecil County

M. D. or other

Date signed

87



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

## CERTIFICATE OF DEATH

03909

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Abraham Kohn

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

Married

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Aug. 5. 1901

6.(c) If alive, give age years

8. AGE:

Years Months Days If less than one day  
45 9 25 hrs. min.

9. Birthplace

Russia (Town, county, and state)

10. Usual occupation

Income tax &amp; auditor

11. Industry or business

12. Name

Jacob Kohn

13. Birthplace

Russia

14. Maiden name

Ida. 13 y

15. Birthplace

Russia

16. Informant

Records - Med Exam

Address of Cecil Co., Md

Removal

Date thereof 6-4-47 (month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery or crematory

Leo P. Gallagher Fun. Home

Location 20 Suburban Ave., Stamford, Conn.

18. Funeral director

Leslie Patterson &amp; Son

Address Perryville, Md

19. June 4 1947

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

World war I U. S. Navy

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947

19. to 19.

and that I last saw h. alive on

Immediate cause of death

Sputulated  
bodyDue to  
Avoglanine Acid

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 5/30-47

Where did injury occur? (City or town) (County) (State)

Injured at home, Farm, Industry, public place, vehicle

Means of injury

Injured at work

Medical Examiner

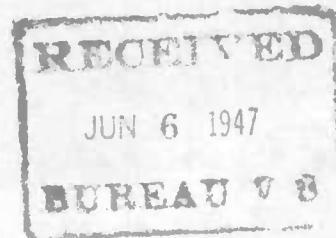
DeDodon J. H. Cecil County

M. D. or other

Address

Date signed 5/30-47

44



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

123

03914

## CERTIFICATE OF DEATH

Reg. Dist. No. 86

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Samuel M. Kohn

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 31 1933

6. (c) If alive, give age

years

8. AGE:

Years      Months      Days      If less than one day

13

8

29

hrs.

min.

9. Birthplace: Stamford, Conn.

(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

12. Name: Abraham Kohn

13. Birthplace: Russia

14. Maiden name: Mary Robinson

15. Birthplace: Stamford, Conn.

16. Informant: Record, Med Examiner

Address: of Rec'd Co., Md

17. Removal

Date thereof: 6-4-47

(month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery or crematory:

Leo P. Gallagher Fun. Home

Location: 20 Suburban Ave., Stamford, Conn.

18. Funeral director: Lee J. Patterson &amp; Son

Address: Perryville, Md

19. June 4 1947

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Conn.

County

City or town: Stamford Conn.

(If outside city or town limits, write RURAL and give nearest town)

Street No: 132 Culloden Road.

(If rural, give LOCATION)

2. (a) If veteran, name war: ✓

## 3. (b) Social Security Number

807

## MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw him alive on

19...

Immediate cause of death: c

DURATION

Decapitated

Due to: Bodily

Due to: Aeroplane Accid

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide:

Date of

Where did injury occur? ...

Date

(City or town)

(County)

(State)

Injured at home, farm, industry, public place, elsewhereMeans of injury: Aeroplane

Injured at work?

23. SIGNATURE:

Medical Examiner

Lee Doctor, M.D.

Rec'd County

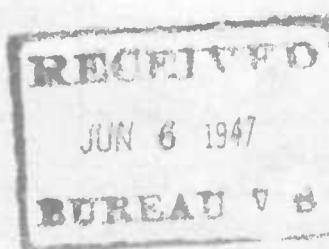
M. D. or other

Address: Rising Sun Md

Date signed

6-2-47

8



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03915

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Della London

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

H White Jr.

6. (b) Name of husband or wife

Jack London

7. Birth date of deceased (mo., day, yr.)

Dec. 22 1907

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Woodridge N.Y.

(Town, county, and state)

10. Usual occupation

Real Estate

11. Industry or business

Jacob Feigin

12. Name

Poland

13. Birthplace

Anna Neuman

14. Maiden name

Poland

15. Birthplace

Abe Feigin

16. Informant

853 Utica N.Y.

Address

Removal

Date thereof 6-3-44

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Riverside Mem. Chapel

Location 76th &amp; Amsterdam Ave N. Y. N.Y.

18. Funeral director

See A. Patterson &amp; Son

Address

Perryville Md.

19. June 3 1947

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

N.Y. Bronx-Manhattan

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

860 Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

ED7

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30

1947 at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to

19.

and that I last saw h. alive on

19.

Immediate cause of death

Fracturation  
of body

DURATION

Due to

Acetophenetidin.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

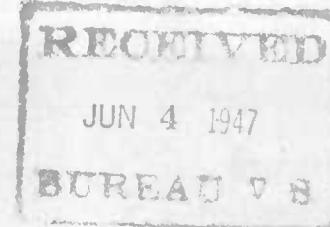
Means of injury Injured at work? Medical Examiner

Police or other

Place of death Date signed

Address

49





6

RECEIVED

JUN 4 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03917

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County..... *Cecil*  
 City or town..... *Elkton, Md.*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 weeks*Hospital, institution, or street address where death occurred: *Union Hospital*How long in hospital or institution? *3 weeks*

## 3. (a) FULL NAME

*Zachery T. Loveless*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M. wh Single*

6. (b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.)

6. (c) If alive, give age..... years

*January 4, 1887*

8. AGE:

Years	Months	Days	If less than one day
60	4	2	hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

*John B. Loveless*

12. Name.....

*New Jersey*

13. Birthplace.....

*John B. Loveless*

14. Maiden name.....

*John B. Loveless*

15. Birthplace.....

*Pa*

16. Informant.....

*Mrs. Mary Loveless*

Address.....

*Chesapeake City, Md.*

17. Burial.....

(Burial, cremation, or removal, which?)

Date thereof..... *May 8/47*

(month day year)

Cemetery or crematory.....

*Bethel*

Location.....

*New Chesapeake City, Md.*

18. Funeral director.....

*H. H. Chapman*

Address.....

*Elkton, Md.*

19. Date rec'd by registrar.....

1947

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md.* County..... *Cecil*  
 City or town..... *Chesapeake City*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war..... *World War I*

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *May 6* 1947 at 2:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*April 16* 1947 to *May 6* 1947and that I last saw him alive on *May 5* 1947

Immediate cause of death.....

*Coronary Thrombosis*DURATION *April 16 -*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

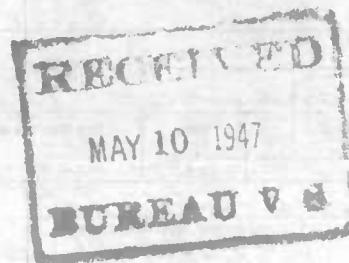
Injured at home, farm, Industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *Orford R. Fletcher, M.D.*

M. D. or other

Address..... *Elkton, Md.* Date signed *May 7, 1947*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03918

96

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Theodore Lundstrom

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W.

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug - 22 - 1916.

B. (c) If alive, give age.....years

8. AGE:

Years      Months      Days      If less than one day  
30      9      8      .hrs.      min.

9. Birthplace

NEW YORK CITY - N.Y.

(Town, county, and state)

10. Usual occupation

Flight Attendant

11. Industry or business

Air Lines.

12. Name

CHARLES LUNDSTROM

13. Birthplace

FINLAND

14. Maiden name

Mae Brown

15. Birthplace

FINLAND

16. Informant

Records Eastern Airlines

Address

New York City

17. Removed

Date thereof..... 6 - 4 - 47  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Chas. F. Krauss FUN. HOME

Location

Franklin Sq. &amp; I. M.Y.

18. Funeral director

Lee A. Patterson &amp; Sons

Address

Perryville, Md

19. Date rec'd by registrar

June 4 1947 Irene E. Daugherty  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State NEW YORK

County NEW YORK

City or town Elmont, Long Island

(If outside city or town limits, write RURAL and give nearest town)

Street No. 82 Randall Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

EDX

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 80 1947 at 642 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Drunken

Due to Body

Due to Airplane

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

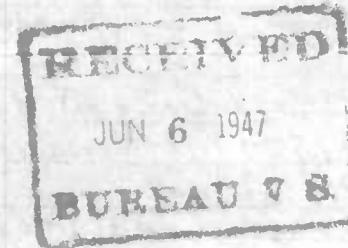
Medical Examiner \_\_\_\_\_

Dr. Cecil County \_\_\_\_\_

M. D. or other \_\_\_\_\_

Date signed 6-3-47

20





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

## CERTIFICATE OF DEATH

03919  
96  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred

How long in hospital or institution

## 3. (a) FULL NAME

Leo Machtet

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. Suite Scumble

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

## 8. AGE:

Years      Months      Days      If less than one day  
26      4      30      hrs.      min.

## 9. Birthplace

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## MOTHER FATHER

S. M. Machtet

Spouse

## MOTHER

14. Maiden name

Miriam Pasternak

## 15. Birthplace

Argentina

## 16. Informant

S. M. Machtet

## Address

Miriam St. La.

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)  
May 31 1947

## Cemetery or crematory

Baltimore, MD

## Location

Leopoldson &amp; Son

Baltimore, MD

18. Funeral director

Address

Swain &amp; Son

(Date rec'd by Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 6:02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.19. to .19. and that I last saw h. alive on .19.

## Immediate cause of death

Aviation accident of body

DURATION

## Due to

Aviation accident

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury (place) Injured at work? Medical Examiner

J. D. O'Leary, M. D. of State

Cecil County Date signed

Address

RECEIVED

JUN 3 1947

BUREAU of

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03920

96

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Greene Stella Machtet

## 3. (b) Social Security Number

ED7

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. White Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

July 14 1817

8. (c) If alive, give age years

8. AGE:

Years 29 Months 10 Days 16 If less than one day hrs. min.

9. Birthplace.....

(Town, county, and state) Florida, Fla.

10. Usual occupation.....

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal  
(Burial, cremation, or removal. Which?)Date thereof May 31 1947  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. May 31 1947  
(Date rec'd by registrar)June E. Daugherty  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

## 2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

ED7

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18..... to.....

19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

Parturition  
of body

DURATION

Due to.....

Obstruction  
decedent

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operation.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

(City or town)

(County)

(State)

Means of injury..... Injured at work?

Medical Examiner

for Cecil County

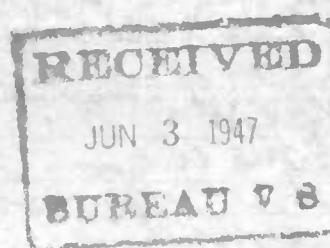
23. SIGNATURE

M. D. or other

Address.....

date signed.....

RECEIVED TO TELETYPE STATE GRANTHAM  
RECEIVED TO TELETYPE STATE GRANTHAM  
RECEIVED TO TELETYPE STATE GRANTHAM



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03921

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Sudden Drowning

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ruth Malan.

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Provo, Utah

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

6-6-47  
(month) (day) (year)

Cemetery or crematory

Greenlake Funeral Home

Location

7217 Woodlawn Ave., Seattle, Wash.

18. Funeral director

Address

Lee L. Patterson &amp; Son

Glenville, Md.

19. Date rec'd by registrar

June 6, 1947

Drene E. Daugherty

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

683 Mercer Place

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

E107

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30, 1947, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h... alive on

19...

Immediate cause of death

Mutilated

Body

Airplane Crash

Due to

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, homicide, etc.

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Medical Examiner

Address

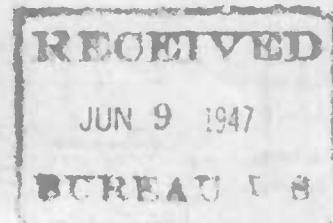
Cecil County

M. D. or other

Date signed

6-5-47

16



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

## CERTIFICATE OF DEATH

Reg. Dist. No. 03922

M

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County... Anne Arundel  
City or town... Elkton Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one day  
Hospital, institution, or street address where death occurred  
Anne Arundel - Elkton

How long in hospital or institution? 30 days -

## 3. (a) FULL NAME

Frank M. Marcus

4. Sex  5. Color or race  6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age... 57 years

7. Birth date of deceased (mo., day, yr.) May 20 - 1887

8. AGE: Years 59 Months 6 Days 14 It less than one day hrs. .... min.

9. Birthplace... Elkton Md  
(Town, county, and state)

10. Usual occupation... Laborer

11. Industry or business... Toyland Marcus

MOTHER FATHER 12. Name... Elkton Md  
13. Birthplace... Elkton Md

14. Maiden name... Anna W Price

15. Birthplace... Cecilton. Md

16. Informant... Mr Jacob Rothwell

Address... Elkton Md

17. Burial Date thereof... May 23 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Elkton cemetery

Location... Elkton Md

18. Funeral director... W C. Wissner

Address... Elkton Md

19. Date rec'd by registrar... May 21 1947  
(Date rec'd by registrar) F. R. Fager  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel  
City or town... Elkton -

(If outside city or town limits, write RURAL and give nearest town)

Street No... 106 Fairview Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 20 - 1947, at 10:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 - 1947, to May 29 1947

and that I last saw him alive on May 19 - 1947

Immediate cause of death... -

Cerebral hemorrhage

Due to... -

Cerebral hemorrhage 1 year

Due to... -

Other conditions... -

(Include pregnancy within 3 months of death)

Major findings or operations... Cerebral hemorrhage

Date of op. 5/11/47

Autopsy results... -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... - Date of... -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... Dr. C. C. Cullinan M.D.

M. D. or other

Address... 106 Fairview Lane Date signed May 21 1947

RECEIVED

MAY 23 1947

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03923

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County.....

Cecil

City or town.....

Carlsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lee Matthews

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

Mr. Mary C. Matthews

7. Birth date of deceased (mo., day, yr.)

Dec. 18, 1880

(c) If alive, give age..... years

8. AGE:

Years  
66

Months

Days

If less than one day

.hrs. .... min.

9. Birthplace.....

Delaware

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

William Matthews

MOTHER

FATHER

12. Name.....

Delaware

William Matthews

13. Birthplace.....

Anya MacLean

14. Maiden name.....

Delaware

15. Birthplace.....

Mrs. Mary C. Matthews

16. Informant.....

Carlsville, Md.

Burial

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Cecilton

Location

Cecilton, Md.

18. Funeral director.....

Edward Fletcher

Address

Willington, Md.

May 23

(Date read by registrar)

19. 47

Mrs. Harvey W. Keyes

Register

Address

Walter H. Lee, M.D.

Injured at work?

M. D. or other

Date signed

5/23/47

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 20, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 7, 1947, to May 20, 1947, and that I last saw him alive on May 18, 1947.

## Immediate cause of death

1. Cardiac hemorrhage

2. Hemiplegia

Due to 1. Hypertension

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

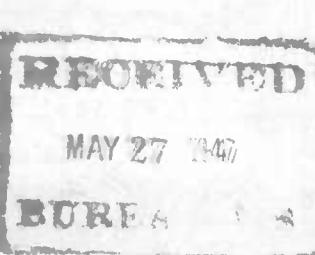
Injured at work?

## 23. SIGNATURE

M. D. or other

Date signed

5/23/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

039246

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

*Decedent*  
Outside Rural  
Sudden Landing

(If outside city or town limits write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M**White**Single.*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Rem. v. a.c.

(Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

*Burial. May 5, 1947*  
Arias McAffe

Cemetery or crematory

Location

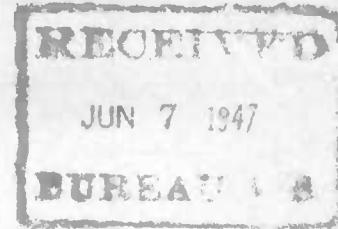
18. Funeral director

Address

19. Date rec'd by registrar

1

50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03925

96

Reg. Dist. No.

## 1. PLACE OF DEATH

County

Port Deposit Rural.  
(If outside city or town limits, write RURAL and give nearest town)

City or town

How long in above place of death

Hospital, institution, or street address where death occurred

How long in hospital or institution

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

43 years

Sept 12 1900

8. AGE:

Years      Months      Days      If less than one day

46      8      18      hrs.      min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

## 11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date of death

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947 at 642 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to

19.

and that I last saw h. alive on

19.

Immediate cause of death

DURATION

Mutilation

Assultation

of body

Surficial

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where)

Means of injury

Injured at work

Medical Examiner

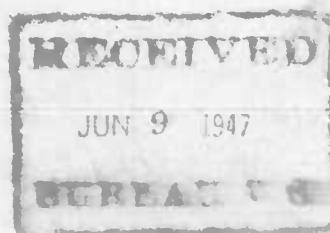
Cecil County

M. D. or other

Date signed

6-5-47

H5



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

03926 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Donna Medeling

## 3. (b) Social Security Number

Sex

M. F.

Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John Medeling

7. Birth date of deceased (mo., day, yr.)

Sept. 6 1907

6. (c) If alive, give age

83

years

8. AGE:

Years

Months

Days

If less than one day

19

9

11

.hrs. .min.

9. Birthplace

Georgia

(Town, county, and state)

10. Usual occupation

H. H. J.

11. Industry or business

Fred. McClain

Furniture

12. Name

Estell Stroud

Estell Stroud

13. Birthplace

Eccs. Fla.

14. Maiden name

John Medeling

John Medeling

15. Birthplace

Cheshire Conn.

16. Informant

Removal

(Burial, cremation, or removal. Which?)

To

Mulville Funeral Home

Location

Waterbury, Connecticut

17. Funeral director

K. A. Patterson &amp; Son

Address

Perryville, Md.

18. Address

3

19. 19

47

June Edelbely

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Street

(If rural, give LOCATION)

2.(a) If veteran, name war

2. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30

1947

al

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Dinitrination

of body

Due to

Cerebral

aneurysm

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner

D. D. or other

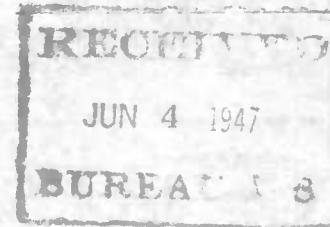
Date signed

Signature

Address

Date signed

43



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

## CERTIFICATE OF DEATH

0392796  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Dorisil Hospital  
Port Royal Hospital  
Sudden Onset

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Murray Miller

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

M. White Married  
Pauline Miller

6. (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.)

May 10 1908

8. AGE:

Years  
39Months  
20Days  
0If less than one day  
hrs. min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

Aynesh Miller

12. Name

Fathers

13. Birthplace

Russia

14. Maiden name

Esther Sachman

15. Birthplace

Russia

16. Informant

Mrs Pauline Miller

Address

732 Penna St. Miami Beach

Removal

(Burial, cremation, or removal. Which?)

Date thereof 6-4-47

(month) (day) (year)

Cemetery or crematory

Bld. Fun. Parlor

Location

Brooklyn

Lee &amp; Patterson Dr

18. Funeral director

Pawleysville, Md.

Address

June 4 1947 Irene E. daughter

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

Dela. County.....

Miami Beach

732 Pennsylvania St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

EDY

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. .... to 19. ....

and that I last saw h. .... alive on 18. ....

Immediate cause of death

Mutilated

Due to Boddy

Airplane

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur Ontonabee Rd. Date of

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Airplane Injured at work?

Medical Examiner

Lee County

M. D. or other

Date signed

Address

98

RECEIVED  
JUN 6 1947  
BUREAU V 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03928  
96

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

HELEN Mary Elizabeth O'BRIEN

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Oct. 13 - 1922

6. (c) If alive, give age..... years

8. AGE:

Years      Months      Days      If less than one day

24      7      17      hrs.      min.

9. Birthplace..... NEW HAVEN, CONN.

(Town, county, and state)

10. Usual occupation..... STEWARDESS

11. Industry or business

Air Lines

12. Name..... DR. WILLIAM H. O'BRIEN

13. Birthplace..... NEW HAVEN, CONN.

14. Maiden name..... No record

15. Birthplace..... BROOKLYN, N.Y.

16. Informant..... RECORDS EASTERN AIR LINES

Address

New York City

17. REMOVAL..... Date thereto..... 6 - 4 - 44

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... M. F. WALTER &amp; SONS

Location..... NEW HAVEN, CONN.

18. Funeral director..... FERGUSON, PATTERSON &amp; SONS

Address..... PENNYVILLE, MD

19. Date rec'd by registrar..... June 4, 1947

Registry

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... CONN.

County.....

City or town..... HAMDEN

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 32 HALL STREET

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

ED7

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 80 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Strangulation

Due to.....

of body

Due to.....

airplane

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of 07/30/47

Where did injury occur..... (City or town) (County) (State)

Injured at home, farm, industry, public place, where?

Means of injury..... Surfplane Injured at work?

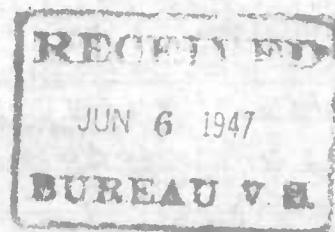
Medical Examiner..... Dr. Rodenrich

or Cecil County

M. D. or other

Date signed..... 6/8/47

38



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03929

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

Martin' Percikow

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

517 W. 161 St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

E07

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

M

White

Married

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

Jan 16 1807.

## B.(c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

40

4

12.

hrs.

min.

## 9. Birthplace

Warsaw- Poland.

(Town, county, and state)

## 10. Usual occupation

Pocket Book Maker.

## 11. Industry or business

Isaac Percikow

## FATHER

## 12. Name

## 13. Birthplace

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Removal

## (Burial, cremation, or removal. Which?)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date of death

## (Date rec'd by registrar)

Date thereof..... 6-4-47  
(month) (day) (year)

Gutterman Funeral Home

153 E. Broadway, New York City

Lee J. Patterson &amp; Son

Perryville, Md

Drene E. Daugherty

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 30 47 at 642 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

## Immediate cause of death

Amputation

of body.

Due to Airplane accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner

Lee Dodson M.D. Cecil County

M. D. or other

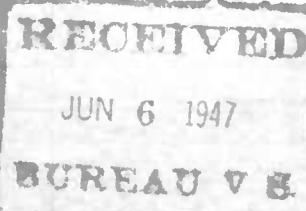
Wesley Lund Date signed 6-3-47

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24

STATE TO STATE MAIL

STATE TO STATE MAIL



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03930

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof  
(month) (day) (year)

Cemetery or crematory

Location

76th &amp; Amsterdam Ave., N.Y.C.

18. Funeral director

Address

19. Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1140 Jackson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

807

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to.

19.

and that I last saw h. alive on

Immediate cause of death

Fractured

Body

airplane

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where)

Means of Injury

Injuring

Carrier

Injured at work

Medical Examiner

Cecil County

M. D. or other

Date signed

Date signed

RECEIVED

JUN 6 1947

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03931

## CERTIFICATE OF DEATH

Reg. Diat. No.

94

## 1. PLACE OF DEATH:

County

Cecil

City or town

North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

LIFETIME

Hospital, institution, or street address where deceased

How long in hospital or institution?

## 3. (a) FULL NAME

Clinton White Turner

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White Widowed

6. (b) Name of husband or wife

Helen Waller Turner

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Dec 2 1862

8. AGE:

Years

Months

Days

If less than one day

84

5

24

hrs.

min.

9. Birthplace

Elk Neck Cecil Co Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

Jefferson Turner

12. Name

MOTHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Burial, cremation, or removal

18. Funeral director

19. Date rec'd by registrar

20. Address

21. Cemetery or crematory

22. Location

23. Signature

24. M. or other

25. Date signed

26. Address

27. Injured at work?

28. Means of injury

29. Date of op.

30. Autopsy results

31. Physician

32. Date of

33. City or town

34. County

35. State

36. Address

37. Date signed

38. Address

39. Date signed

40. Address

41. Date signed

42. Address

43. Date signed

44. Address

45. Date signed

46. Address

47. Date signed

48. Address

49. Date signed

50. Address

51. Date signed

52. Address

53. Date signed

54. Address

55. Date signed

56. Address

57. Date signed

58. Address

59. Date signed

60. Address

61. Date signed

62. Address

63. Date signed

64. Address

65. Date signed

66. Address

67. Date signed

68. Address

69. Date signed

70. Address

71. Date signed

72. Address

73. Date signed

74. Address

75. Date signed

76. Address

77. Date signed

78. Address

79. Date signed

80. Address

81. Date signed

82. Address

83. Date signed

84. Address

85. Date signed

86. Address

87. Date signed

88. Address

89. Date signed

90. Address

91. Date signed

92. Address

93. Date signed

94. Address

95. Date signed

96. Address

97. Date signed

98. Address

99. Date signed

100. Address

101. Date signed

102. Address

103. Date signed

104. Address

105. Date signed

106. Address

107. Date signed

108. Address

109. Date signed

110. Address

111. Date signed

112. Address

113. Date signed

114. Address

115. Date signed

116. Address

117. Date signed

118. Address

119. Date signed

120. Address

121. Date signed

122. Address

123. Date signed

124. Address

125. Date signed

126. Address

127. Date signed

128. Address

129. Date signed

130. Address

131. Date signed

132. Address

133. Date signed

134. Address

135. Date signed

136. Address

137. Date signed

138. Address

139. Date signed

140. Address

141. Date signed

142. Address

143. Date signed

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307. Date signed

RECEIVED

JUN 3 1947

BUREAU C B

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03933

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

**M**  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County..... *Cecil*  
 City or town..... *North East, Rural*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *About 1 year*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Joseph Richardson*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Widowed

8. (b) Name of husband or wife.....

*Effie Richardson*

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

*August 08 1870*

8. AGE:

Years	Months	Days	If less than one day
about 70			hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

*Laborer*

11. Industry or business

12. Name.....

*No*

13. Birthplace.....

14. Maiden name.....

*Information*

15. Birthplace.....

16. Informant.....

Address

17. *Burial* Date thereof *May 14 1947*  
 (Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory *Charlestown Methodist*Location *@ Charlestown, Maryland*18. Funeral director *Joseph R. Evans*Address *North East, Md*19. *5-14-1947* *Leda & Evans*  
 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Cecil*City or town *North East*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

*None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *11 May 1947* at *8:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July 1946* to *11 May 1947*and that I last saw him alive on *11 May 1947*

Immediate cause of death

*Cerebral Thrombosis*

DURATION

*2 days*Due to *Generalized Arteriosclerosis**5 years*Due to *Hypertensive Cardiovascular**Disease**15 years*

Other conditions

*Benign Prostatic Hypertrophy*

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *Klaus H. Huber M.D.* M. D. or other \_\_\_\_\_Address *North East, Md* Date signed *11 May 47*

RECEIVED

MAY 17 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03934

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

96

## 1. PLACE OF DEATH:

County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death .....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? .....

## 3. (a) FULL NAME

Georgina Grillo Rivera

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age .....

years

8. AGE:

Years

Months

Days

If less than one day

hrs. .... min.

9. Birthplace .....

(Town, county, and state)

10. Usual occupation .....

Student

11. Industry or business

Dr. Rafael Grillo

12. Name .....

13. Birthplace .....

14. Maiden name .....

15. Birthplace .....

16. Informant .....

Address .....

Removal

Date thereof .....

6-7-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory .....

Location .....

San Jose, Costa Rica

18. Funeral director .....

Address .....

Lee A. Waller, Esq.,  
Terryville, Md.

19. Date rec'd by registrar .....

(Date rec'd by registrar)

June 7, 1947 Name & signature  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State .....

County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH .....

May 30 1947 at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on .....

19.....

Immediate cause of death .....

Dystocia

.....

Due to .....

Dysfunctional

.....

Due to .....

Cerebral edema

.....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Date of

Where did injury occur? .....

(City of town)

County .....

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injuring person .....

Injured at work?

Medical Examiner .....

John Dodson M.D., Cecil County

M. D. or other .....

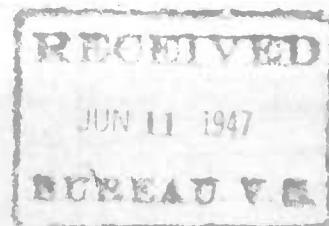
Address .....

Date signed .....

6-3-47

48.

8th



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03935

96

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

6. (c) If alive, give age ..... years

8. AGE: Years      Months      Days      If less than one day

15                     hrs.      min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

6-7-47

Cemetery or crematory.....

Location.....

San Jose, Costa Rica

18. Funeral director.....

Lee A. Patterson &amp; Son

Address.....

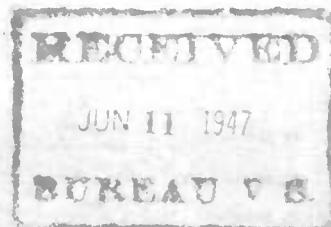
Perryville, Md

19. Date rec'd by registrar.....

UNITED STATES GOVERNMENT

RECEIVED MAIL CARD

3



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03936

## CERTIFICATE OF DEATH

Reg. Dist. No. 9C

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

8. (c) If alive, give age

41

years

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER, FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

18. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

To

Date thereof

(month) (day) (year)

Garretson Funeral Home

Location

Perth Amboy, New Jersey

18. Funeral director

Address

19. June 3 1947

(Date rec'd by registrar)

Irene E. Daugherty

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947 at 642P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19...

19...

and that I last saw h. alive on

19...

Immediate cause of death

Ingestion of Bodily

Due to

Anesthetics

Due to

Anesthetics

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner

Cecil County

23. SIGNATURE

M. D. or other

Address

Date signed

8-1-47

39

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JUN 4 1947

FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1646

03932

## CERTIFICATE OF DEATH

Reg. Dist. No.

90

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, year)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Camden, N.J.

(Town, county, and state)

10. Usual occupation

Boat carpenter

11. Industry or business

James A. Ross

12. Name

James A. Ross

13. Birthplace

Brooklyn, N.Y.

14. Maiden name

Helena A. Evans

15. Birthplace

Brooklyn, N.Y.

16. Informant

James A. Ross

Address

Fredericktown

17. Burial

Burial

Date thereof (month) (day) (year)

Cemetery or crematory

Calvary Cemetery

Location

Calvary Cemetery

18. Funeral director

Edward J. Miller

Address

Millington, Md.

19. May 19, 1947

Date rec'd by registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

213-25-7965

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16 1947 at M.G. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h. alive on

19...

Immediate cause of death

Liver shock  
second of lead

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

Fredericktown, Md. 5/18/47

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

None

Means of injury

Injured at work?

23. SIGNATURE

Address

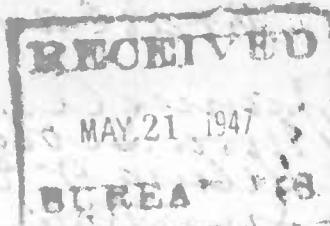
Registrar

Medical Examiner

for Cecil County

M. D. or other

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03937

## CERTIFICATE OF DEATH

173  
Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

Bryn Mawr  
Out-Door Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Sudden Cardiac

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Nirardo Lopez Rueda.

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

M wife single.

## 6. (b) Name of husband or wife

## 8. (c) If alive, give age

years

## 7. Birth date of deceased (mo., day, yr.)

May 24 1924

## 8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

(Town, county, and state)

Mexico

## 10. Usual occupation

Ballet Dancer.

## 11. Industry or business

unknown.

## FATHER

## 12. Name

Lopez

## 13. Birthplace

Sevora Sevora Lopez

## 14. Maiden name

Mexico

## 15. Birthplace

Norman Rock.

## 16. Informant

64 West 56th N.Y.

## Address

Cremation Date thereof 6-6-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Greenmount Cemetery

## Location

Baltimore, Maryland

## 18. Funeral director

Lee A. Patterson &amp; Son

## Address

Gwynn Valley, Md.

## 19. Date rec'd by registrar

June 6 1947

(Date rec'd by registrar)

Name E. Daugherty

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

N.Y.

County

New York

City or town

New York

(If outside city or town limits, write RURAL and give nearest town)

Street No.

64 West 56th

N.Y.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

May 30 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

19.

and that I last saw h.....alive on

19.

## Immediate cause of death

Inhalation  
of body

Due to

Auto Plane

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

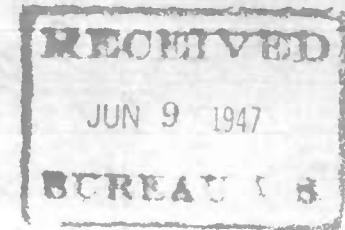
Means of injury Injured at work?

23. SIGNATURE

Lee A. Patterson &amp; Son

Medical Examiner  
Lee A. Patterson & Son  
M. D. or other  
Date signed

33



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

03938

## CERTIFICATE OF DEATH

Reg. D. I. A. No.

96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

E07

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947 6420

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h alive on

Immediate cause of death

Myocardial

Due to

Toxology

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, Farm, Industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner

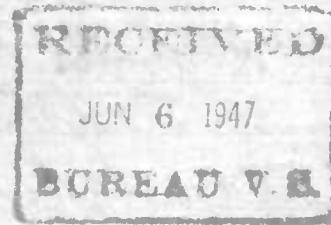
for Cecil County

M. D. or other

Date signed

Address

4  
RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASH. 25, D. C.





RECEIVED

JUL 24 1947

BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

## 1. PLACE OF DEATH:

County..... *Cecil*  
 City or town..... *Newark, Rockport, Md.*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *14 years*Hospital, institution, or street address where death occurred: *Carrolville*

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

*John Wallace Scott*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*M. Wh. Divorced*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *October 14, 1879*

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

8. Birthplace.....

(Town, county, and state) *Georgetown, Pa*

10. Usual occupation.....

*Retd Farmer*

11. Industry or business

12. Name..... *John H. Scott*13. Birthplace *Phila, Pa*14. Maiden name *Marylin Park*15. Birthplace *Phila, Pa*

16. Informant.....

*John Scott*Address *218. Hewett Road, Boyce, Pa*

17. Burial.....

Date thereof *May 19, 1947*

(month) (day) (year)

(Burial, cremation, or removal. Which?)

*West Laurel Hill*

Cemetery or crematory

Location *Phila, Pa*18. Funeral director *H. W. Scott*Address *Elkton, Md*19. Date rec'd by registrar *May 18, 1947*

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Ind* County..... *Cecil*City or town..... *New Carrollton, Ind*  
 (If outside city or town limits, write RURAL and give nearest town)Street No..... *110* (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *16 May 1947* at *8 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*7 April 1947* to *16 May 1947*and that I last saw him alive on *16 May 1947*

Immediate cause of death.....

*myocardial failure* DURATION *1 day*Due to *Acute Cardiac Dilatation* *1 day*Due to *Chronic Myocarditis* *7 Apr 47*Other conditions *Arteric Insufficiency* *7 Apr 47*

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

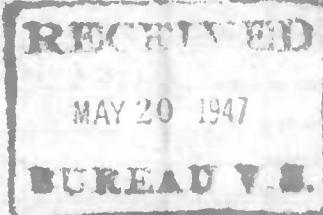
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE *Allen R. Crenshaw, M.D.* M. D. or other *Middleton, Del*Address *Middleton, Del* Date signed *16 Apr 47*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

300  
03940

## CERTIFICATE OF DEATH

96

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County..... **Cecil**

City or town..... **Perry Point, Md.**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **1 yr. 5 mos. 28 days**

Hospital, institution, or street address where death occurred:

**Veterans Adm. Hosp., Perry Point, Md.**

How long in hospital or institution?..... **Since July 27, 1945**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... **North Carolina** County..... **Davidson**

City or town..... **Thomasville**  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... **c/o South Side Store**

(If rural, give LOCATION)  
**Peace Time & WW-II**

2.(a) If veteran, name war..... **✓**

## 3. (a) FULL NAME

**SEBASTIAN, Richard**

4. Sex..... **Male** 5. Color or race..... **White** 6.(a) Single, married, widowed, or divorced..... **Divorced**

6.(b) Name of husband or wife..... **—**

7. Birth date of deceased (mo., day, yr.)..... **March 19, 1909** 6.(c) If alive, give age..... years

8. AGE: Years..... **38** Months..... **1** Days..... **21** If less than one day..... hrs..... min.....

9. Birthplace..... **Thomasville, N.C.**  
(Town, county, and state)

10. Usual occupation..... **Textile worker**

11. Industry or business..... **Textile mills**

FATHER 12. Name..... **Henry Clay Sebastian - deceased**

MOTHER 13. Birthplace..... **North Wilkesboro, N.C.**

14. Maiden name..... **Mary Combs - deceased**

15. Birthplace..... **Roaring River, N.C.**

16. Informant..... **Brother, J.A. Sebastian**

Address.....

17. Burial..... **Burial** Date thereof..... **May 13, 1947**  
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... **Conway**

Location..... **Thomasville, North Carolina**

18. Funeral director..... **PENNINGTON & SON**

Address..... **Havre de Grace, Md.**

19. **May 10 1947 Irene E. Daugherty**  
(Date reg'd by registrar) **Registrar**

## 3. (b) Social Security Number

**None**

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May 10** 1947, at **12:10 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **November 12, 1945**, to **May 10, 1947**, and that I last saw h. **1 m.** alive on **May 10, 1947**.

Immediate cause of death

**Meningitis (acute cerebrospinal meningitis (not due to meningo- coccus**

Due to

Due to

Other conditions..... **Lobular pneumonia**

**Psychosis with syphilis of the central nervous system, meningo-encephalitic type**

Major findings of operations

— Date of op.

Autopsy results..... **Same as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... **—** Date of 1.

Where did injury occur?..... **—** (City or town) (County) (State)

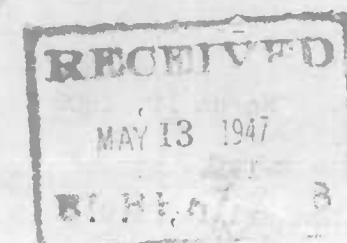
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

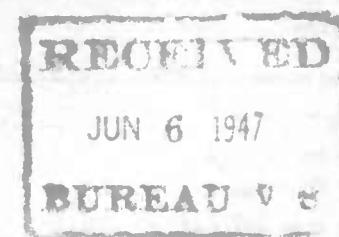
23. SIGNATURE **A. E. TROLLINGER** M. D. or other

Address..... **VAH, Perry Point, Md.** Date signed **May 10 1947**





14



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03942

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

*At her home in rural Sudden Landing*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Adelaide Solin*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*H. wife Single.*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

*May 30 - 1907*

8. AGE:

Years

Months

Days

11 less than one day

hrs. min.

*40*

9. Birthplace

(Town, county, and state)

*Bayonne N.J.*

10. Usual occupation

*Librarian.*

11. Industry or business

FATHER

12. Name

*Mary Solinsky*

13. Birthplace

14. Maiden name

MOTHER

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

*cremation**Ralph E. Fiedner Fun. Home*

Location

*Great Neck, Long Island, N.Y.*

18. Funeral director

Address

*Lev A. Patterson & Son**Buryville, Md.*

19. June 3 1947

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

34 W. 10th

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*May 30 1947*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10.

19.

and that I last saw h. alive on

19.

Immediate cause of death

*Fractured*

Due to

*body.*

Due to

*Argyline em.*

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (which?)

Means of injury

Injured at work?

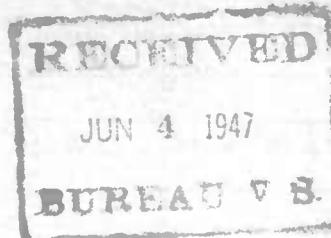
Medical Examiner for Cecil County.

M. D. or other

Date signed

Address

34



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03943

Reg. Dist. No. 96

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, institution, or street address where death occurred.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Cynthia Solin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

H

White

Single.

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Dec. 23 1923

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

24

3

7

9. Birthplace.....

(Town, county, and state)

New York City N.Y.

10. Usual occupation.....

Secretary

11. Industry or business

Max L. Solinsky

12. Name.....

Max

L.

Solinsky

13. Birthplace

New

York

City

14. Maiden name

Ray

Friedler

15. Birthplace

February

Latvia

16. Informant.....

Max L.

Solin

17. Removal.....

2589 Brookwood Driv

E

Date thereof..... 0-5-47

(month) (day) (year)

(Burial, cremation, or removal. Which?)

To

Ralph Fliedner Fun. Home

18. Funeral director.....

See A.

Patterson &amp; Son

19. Address.....

Auriville

Md.

20. Date rec'd by registrar.....

Jan

3

1947

Irene E. Daugherty

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

N.Y.

County.....

New York

City or town.....

New

York City

Street No. 34 W-10th st

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

EDY

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 30 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

Immediate cause of death.....

Mutilated body

Due to.....

Airplane accident

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)

Means of injury.....

Injured at work?

Medical Examiner

Cecil County

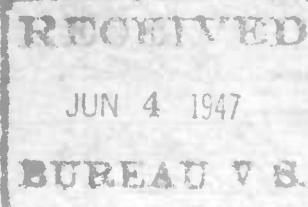
M. D. or other

Date signed

Address.....

Address.....

35-



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03944

96

## CERTIFICATE OF DEATH

113  
Reg. Dist. No.

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

March 23 1902.

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Arlington Hill 29 N.Y.

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location 8601 Lefferts Blvd., Richmond Hill, N.Y.

18. Funeral director

Address

Lee &amp; Patterson, Inc.

19. June

19. 47

Date rec'd by registrar

Date

Date

Date

Date

Date

Date

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

County

Nearest town

2123-1201

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

EDY

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947 at 645 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

to

19...

and that I last saw h. alive on

19...

Immediate cause of death

Fractilated  
body.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

County

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Injured at work?

Medical Examiner

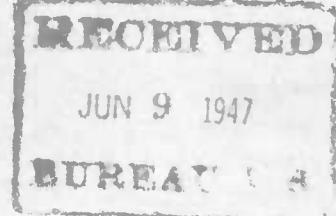
Cecil County

M. D. or other

Date signed

Date signed

13



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

## CERTIFICATE OF DEATH

Reg. Dist. No. 039456

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

arlene sternstein

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, year)

8. AGE:

Years Months Days If less than one day hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Edward Lauterbach

Luthra

12. Name

Tessie Kolker

13. Birthplace

New Jersey

14. Maiden name

Tessie Kolker

15. Birthplace

Bridgeton

16. Informant

101 Eileen St.

Address

Removal

Date thereof 64 - 4 - 47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Silberg Memorial Chapel

Location 864 Madison Ave Albany, N.Y.

18. Funeral director Lee A. Patterson, Jr.

Address Perryville, Md.

19. Date rec'd by registrar June 4 1947 June E. Dougherty

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2.(a) If veteran, name war

## 3. (b) Social Security Number

E07

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 30 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Decapitated body

Due to

Avoglanic acid

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur Pat Deppert and Md. (City or town) County (State)

Injured at home, farm, industry, public place (where?)

Means of injury Avoglanic Injured at work?

Medical Examiner

Place of death

County

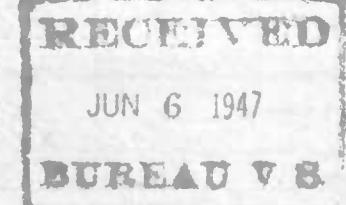
M. D. or other

Date signed

Address

Date signed

12.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03946

## CERTIFICATE OF DEATH

Reg. Dlat. No. 96

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Riverside Chapel

Location

Far Rockaway, Long Island, N.Y.

18. Funeral director

Address

19. June 4, 1947

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 30, 1947, at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw h..... alive oo..... 19.....

Immediate cause of death

DURATION

Amputation of

Body

Due to

Arterial embolism

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, orthomicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (Where)

Means of injury

Injured at work

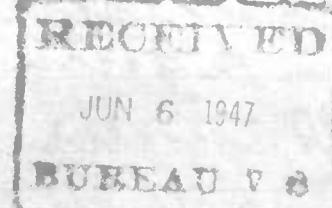
Medical Examiner

Cecil County

M. D. or other

Date signed

17



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03947

## CERTIFICATE OF DEATH

Reg. Distr. No. \_\_\_\_\_

## 1. PLACE OF DEATH:

County ..... **Cecil**City or town ..... **Port Deposit**

(If outside city or town limits, write RURAL and give nearest town)

**Life**

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

## 3. (a) FULL NAME

**Kate Morrison Strout**4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Widowed**6. (b) Name of husband or wife **Theodore H. Strout**7. Birth date of deceased (mo., day, yr.) **March 28, 1856**

6. (c) If alive, give age ..... years

8. AGE: Years **91** Months **2** Days **1** If less than one day hrs. ..... min. ....9. Birthplace **Port Deposit, Cecil Co., Md.**  
(Town, county, and state)10. Usual occupation **House Wife**

## 11. Industry or business

12. Name **Hamilton Morrison**13. Birthplace **Penna.**14. Maiden name **Elizabeth Ulrick**15. Birthplace **Switzerland**16. Informant **Mrs James Downs**Address **Port Deposit, Md.**17. Burial **West N ottingham** Date thereof **May 31, 1947**  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory **Colora, Md. Rural**Location **P. A. Patterson & Son**18. Funeral director **Perryville, Md.**Address **May 31, 1947 Irene E. Daugherty**

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Cecil**City or town ..... **Port Deposit**

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH **5-29** 1947 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**5-27** 1947, to **5-29** 1947and that I last saw h. e. alive on **5-28-47** 1947

Immediate cause of death

**Coronary Thrombosis** DURATION **72 hrs.**Due to **Chronic Myocarditis**Due to **Senility**

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

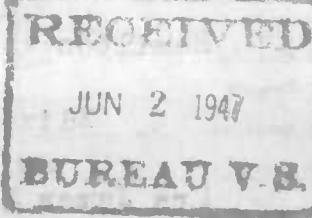
Means of injury

Injured at work? .....

23. SIGNATURE **W. L. Edwards, M.D.**

M.D. or other

Address **Benton P. S. I. H. 5-15-X** Date signed **May 31, 1947**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03948

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

35

years

8. AGE:

Years	Months	Days	If less than one day
39	7	12	hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal Which?)

Date thereof (month) (day) (year)

To

Gutterman Funeral Home

Location

Jersey City, New Jersey

18. Funeral director

Address

J. A. Patterson & Son  
Perryville, Md.

19. June 3 1947

(Date rec'd by registrar)

Irene E. Daugherty  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Dela. County Dade.  
Marin Beach.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1037

Actor Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 640 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h. alive on 19...

Immediate cause of death

Inhalation of Body

DURATION

Due to

Due to Asphyxiation  
Accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

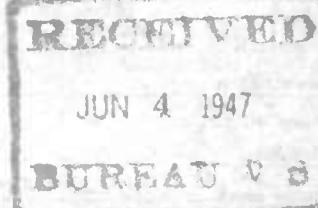
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work Medical Examiner

Pneumonitis Injured at home Medical Examiner

Pneumonia Injured at work Medical Examiner

47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03949

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

## 1. PLACE OF DEATH:

County

Metropolitan Rural

(If outside city or town limits, write RURAL and give nearest town)

City or town

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M. White Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age

years

May 28 1946

8. AGE:

Years

Months

Days

If less than one day

1

2

. hrs.

. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof.....

(month)

6-3-47

(day)

(year)

To

Gutterman Funeral Home

Location

Jersey City, New Jersey

18. Funeral director

Address

Lee A. Gutterman &amp; Son

Terryville, Md.

19. June 3 1947

(Date rec'd by registrar)

James E. Daugherty

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

103

Alton Rd.

Dade.

Miami Beach.

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....

19.....

and that I last saw h.....alive on.....

19.....

Immediate cause of death

My mitigation of  
Poody.

DURATION

Due to

Airplane accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

Medical Examiner

for Death County

Address Date signed

M. D. or other

M

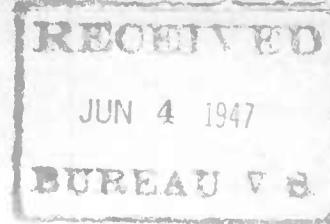
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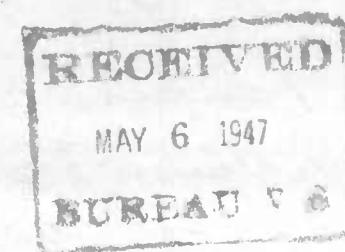
VS A15 9-45-15-M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47.9







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318

03951

86

## CERTIFICATE OF DEATH

Reg. Dlat. No. ....

## 1. PLACE OF DEATH:

County ..... **Cecil**  
 City or town ..... **Port Deposit**

(If outside city or town limits, write RURAL and give nearest town)

25 yrs.

How long in above place of death? .....  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 3. (a) FULL NAME

**Sarah Elizabeth Taylor**

4. Sex ..... 5. Color or race ..... 6. (a) Single, married, widowed, or divorced

**Female** **Colored** **Widowed**6. (b) Name of husband or wife ..... **Daniel Taylor**7. Birth date of deceased (mo., day, yr.) ..... **June 6, 1903**

6. (c) If alive, give age ..... years

8. AGE: Years ..... **43** Months ..... **11** Days ..... **0** If less than one day ..... hrs. ..... min.9. Birthplace ..... **Stauntonville, Augusta Co., Va.**

(Town, county, and state)

10. Usual occupation ..... **House Wife**

## 11. Industry or business

FATHER 12. Name ..... **Samuel Morton**

Va.

MOTHER 13. Birthplace ..... **Unknown**14. Maiden name ..... **Unknown**15. Birthplace ..... **Unknown**16. Informant ..... **Isabel Taylor**Address ..... **Port Deposit, Md.**17. Burial ..... **Burial** Date thereof ..... **May 9, 1947**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory ..... **St. James**Location ..... **Havre De Grace, Md. Rural**18. Funeral director ..... **Lu A. Patterson & Son**Address ..... **Perryville, Md.**19. Date reg'd by registrar ..... **May 9, 1947** Irene E. Dugdell, Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... **Maryland** County ..... **Cecil**City or town ..... **Port Deposit** (If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (b) Social Security Number

**May 6, 1947-55 PM**

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... **May 6, 1947** at **1155 PM**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **March 20, 1947** to **May 5, 1947**and that I last saw her ..... alive on **May 5, 1947**Immediate cause of death ..... **Chronic Myocarditis** DURATION **5**Due to ..... **Endocarditis**Due to ..... **Chronic Nephritis** DURATION **5**Other conditions ..... **Chronic Nephritis** DURATION **5**

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results ..... Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of ....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? ....

23. SIGNATURE ..... M. D. or other ..... Date signed ..... Address ..... **B. Johnson, M.D.** **5/17/47**Date signed ..... **5/17/47**

RECEIVED

MAY 12 1947

BUREAU of S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03952

173

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, Institution, or street address where death occurred.....

How long in hospital or institution?

## 3. (a) FULL NAME

Son. On.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M Yellow Married

6. (b) Name of husband or wife.....

Mon. Sree

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 45 years

1899.

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Canton China

(Town, county, and state)

10. Usual occupation.....

People.

11. Industry or business

Torn Son Son.

12. Name

NYC Chinese State

13. Birthplace

Torn Son Son.

14. Maiden name

Torn Son Son.

15. Birthplace

State China

16. Informant

Chester Torn

17. REMOVAL

Date thereof 6-6-44

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Benjamin Kim &amp; Son

Location

28 Mulberry St. N.Y.C.

18. Funeral director

Lee A. Patterson &amp; Son

Address

Perryville, Md.

19. (Date rec'd by registrar)

19. (Date)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

China County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1944

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to. 19.

and that I last saw h. alive on.

Immediate cause of death

Articulated

body.

Due to.

Airplane

Due to.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide. Date of 5/30/47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury (injury) Injured at work?

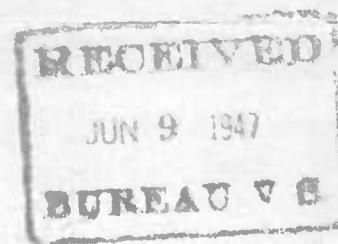
Medical Examiner or Coroner

or Coroner's Office

M. D. or other

Date signed 6-5-47

157



V 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTE: There are 53 certificates of these deaths for 53 persons, PLUS this cer. for "one case of material . . . MARYLAND STATE DEPARTMENT OF HEALTH  
unidentifiable parts . . . cremated 2411 N. Charles St., Baltimore 173  
at Greenmount . . ." -quoted from CERTIFICATE OF DEATH  
Dr. Dodson's letter 7-31-47 G111 - LL 03953  
Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Unidentifiable tissue*  
(ONE BOX OF UNIDENTIFIABLE PARTS - cremated as below)

3. (b) Social Security Number *E07*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Airplane Wreck*

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age ..... years

8. AGE: Years      Months      Days      If less than one day  
..... hrs. ..... min.9. Birthplace *Unknown* (Town, county, and state)10. Usual occupation *Unknown*11. Industry or business *Unknown*MOTHER FATHER  
12. Name.....  
13. Birthplace

14. Maiden name.....

15. Birthplace *Unknown*16. Informant *Alie Dodson & Son*Address *Rising Sun Md.*17. (Burial, cremation, or removal, which?) *Cremation* Date thereof *June 6 1947* (month) (day) (year)Cemetery or crematory *Greenmount Crematory*Location *Baltimore, Md.*18. Funeral director *Alie A. Patterson & Son*Address *Rising Sun Md.*19. *June 6 1947* *Irene E. Sanders* *Registrar*  
(Date rec'd by registrar) *Address*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

## 2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May 30 1947*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. .... to 19. ....

and that I last saw h. .... alive on 19. ....

Immediate cause of death

*Mutilation*  
*of bodies*

DURATION

Due to

Due to

*Airplane Crash*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

*Alie Dodson & Son*  
*Rising Sun Md.* *June 6 1947*  
M. D. or other  
Address

RECEIVED

JUN 9 1947

BUREAU OF



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03961

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County.....

Cecil

City or town.....

Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 days

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

2 days

## 3. (a) FULL NAME

Vadensis Ray Wayne

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

single

## 6. (b) Name of husband or wife

August 1946

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

August 1, 1946

## 8. AGE:

Years

Months

Days

If less than one day

9 19

hrs.

min.

## 9. Birthplace.....

Elkton, Maryland

(Town, county, and state)

## 10. Usual occupation.....

infant

## 11. Industry or business

## 12. Name.....

Raymond J. Vadensis

## 13. Birthplace

Walterboro, South

## 14. Maiden name.....

Lorraine J. Oftthause

## 15. Birthplace

Perryville, Md

## 16. Informant.....

Vadensis Vadensis

## Address.....

283 Nallingworth Manor.

## 17. (Burial, cremation, or removal. Which?)

## Cremation

Date thereof.....

(month) (day) (year)

## Cemetery or crematory

Nelwells

## Location.....

Post Deplasif Rd. Pung

## 18. Funeral director.....

Lee A. Patterson Esq.

## Address.....

Perryville, Md.

## 19. (Date rec'd by registrar)

May 21, 1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 283 Nallingworth Manor

(If rural, give LOCATION)

## 2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... May 20 1947 at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18 1947 to May 20 1947

and that I last saw him alive on May 20 1947

## Immediate cause of death.....

① Pneumonia, heart trouble

② Diarrhea, some type an

Due to..... Cane intestinal

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

## Major findings of operations.....

Date of op.....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work.....

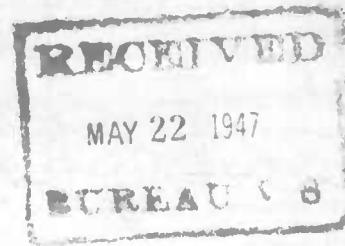
23. SIGNATURE..... S. Ralph Wayne, Jr., M.D.

M. M. or other

Address..... 2318 Main St.

Date signed..... May 21, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





RECEIVED

JUN 6 1947

BUREAU V.B.

**PLEASE WRITE PLAINLY, WITH UNREADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03954

173

**CERTIFICATE OF DEATH**

Reg. Diat. No. ....

90

1. PLACE OF DEATH: *Pat Deposit Rural*  
 County: *Pat Deposit* City or town: *Rural*  
 (If outside city or town limits, write RURAL and give nearest town)

2. How long in above place of death: *Sudden*  
 Hospital, institution, or street address where death occurred:

3. How long in hospital or institution?

3. (a) FULL NAME: *KENNETH V. Willingham*

4. Sex: <i>M.</i>	5. Color or race: <i>W.</i>	6. (a) Single, married, widowed, or divorced: <i>MARRIED.</i>
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6. (b) Name of husband or wife: *✓*

7. Birth date of deceased (mo., day, yr.): *JUNE - 3 - 1919* 8. (c) If alive, give age: *✓* years

8. AGE: Years: *27* Months: *11* Days: *27* If less than one day: *hrs.* *min.*

9. Birthplace: *Roswell NEW MEXICO* (Town, county, and state)

10. Usual occupation: *Pilot*

11. Industry or business: *Air LINE*

12. Name of father: *ROBERT LEE Willingham*

13. Birthplace of father: *MIDLAND - TEXAS.*

MOTHER FATHER

14. Maiden name of mother: *STERLING SHIELDS*

15. Birthplace of mother: *PICKENS TEXAS*

16. Informant: *Records Eastern Air Lines*  
 Address: *NEW YORK CITY*

17. Cemetery or crematory: *RIMOVAGE* Date thereof: *6-4-43*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Location: *VERNON, TEXAS* Cemetery or crematory: *UNDERWOOD FUN HOME*

18. Funeral director: *Lee & Patterson & Son*  
 Address: *Perryville, MD.*

19. Date rec'd by registrar: *June 4 47* Irene E. Daugherty  
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Fla County \_\_\_\_\_

City or town Miami (If outside city or town limits, write RURAL and give nearest town)

Street No. 4450 S. W. 52nd STREET (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (b) Social Security Number ED 1947 6420

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Mutilated Body Airplane Crash DURATION

Due to Mutilated Body

Due to Airplane Crash

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operation  Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Accident Date of 07-30-45

Where did injury occur? Fort Deposit Cen. Ind. (City or town) Public Carrier (County) State

Injured at home, farm, Industry, public place (where?)

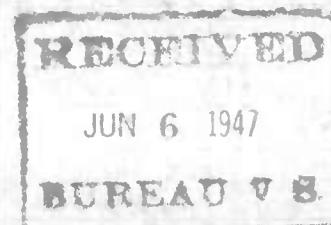
Means of injury Blowdown Injured at work?

Medical Examiner Cecil County  
M. D. or other M. D. on other Date signed 6-3-47

23. SIGNATURE Alfredo de Leon

Address 1315 5th Street

15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03957

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County CecilCity or town Mary Perry Point  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrs. 2 mos. 23 days

Hospital, institution, or street address where death occurred:

Veterans Adm. Hosp., Perry Point, Md.How long in hospital or institution? Since Jan. 4, 1939

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Middle River  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. 15, Box 248

(If rural, give LOCATION)

WW-II

2.(a) If veteran, name war

## 3. (a) FULL NAME

WISE, George N.4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife —7. Birth date of deceased (mo., day, yr.) March 13, 1896 6.(c) If alive, give age years8. AGE: 51 Years 2 Months 16 Days If less than one day hrs. min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Guard (Customs House)

## 11. Industry or business

12. Name George N. Wise - deceased13. Birthplace Maryland14. Maiden name Mary Ritz15. Birthplace Maryland16. Informant Hospital Records

## Address

17. Removal Removal Date thereof May 30, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Unknown

## Location

Pennington & Son18. Funeral director PENNINGTON & SON  
Address Havre de Grace, Md.19. May 30 1947 Irene E. Daugherty  
(Date rec'd by registrar) Registrar3. (b) Social Security Number  
Unknown

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 19 47 at 1:40 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 47 to May 29, 19 47 and that I last saw h. 1 m. alive on May 29 19 47.

Immediate cause of death

Embolic phenomena, multiple

DURATION

2 mos.Due to Arteriosclerosis, generalized UnknownDue to Hypertensive cardio-vascular renal disease Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results Same as above

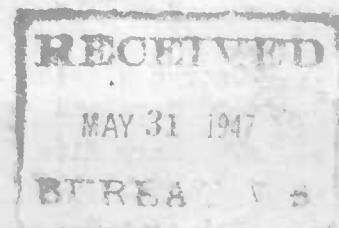
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State) —Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —

23. SIGNATURE

A. E. TROLLINGER, M.D., Clinical Director  
Address VAH, Perry Point, Md. Date signed 5-29-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03955

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Cecil  
County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? since 3/15/47 (2 mo.)

3. (a) FULL NAME

4. Sex F. 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife April 21, 1887 8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1887

8. AGE: Years 60 Months 0 Days 16 If less than one day hrs.  min.

9. Birthplace Buffalo, N. Y. (town, county, and state)

10. Usual occupation House Keeper

11. Industry or business John Walmsley

12. Name John Walmsley

13. Birthplace Maryland

14. Maiden name Virginia Vickers

15. Birthplace Virginia

16. Informant Hospital Record

Address Union Hospital Elkton Md

17. Burial Burial Date thereof May 10, 1947 (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md

18. Funeral director H. W. Pippin

Address Elkton, Md

19. May 9, 1947 (Date rec'd by registrar) J. R. Fraser (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Elkton (If outside city or town limits, write RURAL and give nearest town)

Street No. 227 E Main St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1947 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.25 to May 7, 1947

and that I last saw her alive on May 7, 1947

Immediate cause of death Pulmonary Edema

DURATION 1 day

Due to Lung's Congestion

Due to

Other conditions Chronic Endocarditis

& Chronic Myocarditis (Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

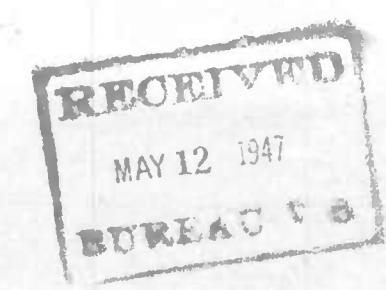
Where did injury occur?  (City or town)  (County)  (State)

Injorod at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. R. Fraser M.D. or other

Address Elkton, Md Date signed May 9, 1947



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03958

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?  
.....

## 3. (a) FULL NAME

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) jan 11 1882 8. (c) If alive, give age..... years

8. AGE: Years 65 Months  Days  If less than one day  
..... hrs. ..... min.

9. Birthplace.....  
(Town, county, and state) md

10. Usual occupation..... farmer

11. Industry or business.....

12. Name..... john T. Woolleyham

13. Birthplace..... md

14. Maiden name..... Rachel Hawley

15. Birthplace..... md

16. Informant..... Mrs. Jessie Woolleyham

Address..... Eastville md

17. (Burial, cremation, or removal, which?) Burial Date thereof. May 29 1947  
(month) (day) (year)

Cemetery or crematory..... Johnstown

Location..... Rural Eastville md

18. Funeral director..... Edward Hawley

Address..... Bullockton md

19. May 28 1947 Mrs. Jessie Woolleyham  
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... MD City or town..... Rural Eastville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH 26 May 1947 at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 May 1947 to 26 May 1947 and that I last saw h. alive on 25 May 1947

Immediate cause of death.....

Carcinoma of the  
uterus DURATION May 27

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

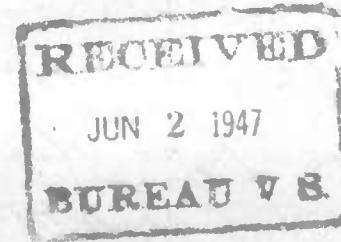
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Moons of injury..... Injured at work?

23. SIGNATURE..... Allan R. Crutchley M. D. or other

Address..... Middletown, Pa. Date signed 28 May 1947



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03959

## CERTIFICATE OF DEATH

131a  
Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

Since 4/9/47

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

City or town.....

(If rural, give LOCATION)

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Dec 24, 1866

8. AGE: Years Months Days If less than one day

89 4 14 hrs. min.

9. Birthplace.....

(Town, County, and state)

10. Usual occupation.....

## 11. Industry or business

12. Name.....

David Germekessel

Germ.

13. Birthplace.....

Germ.

14. Maiden name.....

Sara Hoffman

Germ.

15. Birthplace.....

Germ.

16. Informant.....

Hospital Record, their wife

Address

Elkton 2nd

17. Burial.....

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Elkton, Md

Location.....

Elkton, Md

18. Funeral director.....

H. H. Huppins

Address

Elkton, Md

19. Date reg'd by registrar.....

May 9 1947

(Date reg'd by registrar)

F. R. Frazer

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 8 1947 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1947 to 1947

and that I last saw her alive on May 8 1947

Immediate cause of death..... Central embolus

DURATION

Due to..... Cardiac renal vascular disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

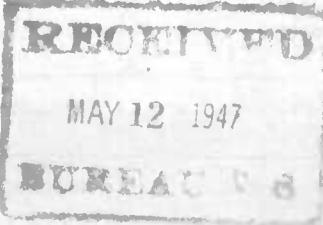
Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other.....

Address.....

Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03960

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County Cecil  
City or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital of Cecil County  
How long in hospital or institution? 8 hours

## 3. (a) FULL NAME

Peter C. Wright

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Irene Wright

7. Birth date of deceased (mo., day, yr.) November 27 - 1870  
8. (c) If alive, give age 80 years

8. AGE: Years 76 Months 5 Days 7 If less than one day hrs. min.

9. Birthplace Merton, Wisconsin  
(Town, county, and state)

10. Usual occupation Retired Clergyman

## 11. Industry or business

12. Name Charles Wright

13. Birthplace Wisconsin

14. Maiden name Phoebe Neal

15. Birthplace Wisconsin

16. Informant Mrs. Irene Wright

Address Hollars, New York

17. Removal Date thereof May 2, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Maplewood

Location Norwicht, Conn.

18. Funeral director H.W. Pippin

Address Elkton, Md.

19. Date rec'd by registrar May 5, 1947  
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State New York County 9405

City or town Hollars  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 19824 Carpenter Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1947 at 9:30 A.M. E.D.T.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death

Coronary thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?

Means of injury

Injured at work?

Medical Examiner  
for Cecil County

23. SIGNATURE

P. de Dodson  
Physician Dr. Young & Son M.D. Date signed May 5, 1947

RECEIVED

MAY 6 1947